



Doctors Medical Center Management Authority, JPA Board Meeting

Wednesday, June 23, 2010

3:00 PM – Auditorium

Doctors Medical Center

2000 Vale Road

San Pablo, CA

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY

**Doctors Medical Center Management Authority,
JPA Board
Wednesday, June 23, 2010 – 3:00 pm
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806**

Governing Board
Supervisor John Gioia, Chair
Stephen Arnold, M.D.
Pat Godley
Supervisor Federal Glover
Bill Walker, M.D.
Beverly Wallace
Eric Zell

AGENDA

1. Call to Order and Roll Call
2. Approve Minutes of Board Meeting of May 26, 2010
3. Public Comment
[At this time persons in the audience may speak on any items not on the Agenda which are within the jurisdiction of the Doctors Medical Center Management Authority.]
4. Presentation and Acceptance of the May 2010 Financial Statements
5. Paragon Information Systems: *Recommendation to the District Board to purchase implement Paragon Information System*
6. Employee Health Benefits: *Approval of Keenan and Associates T.P.A. Contract*
7. CEO Report

Closed Session

8. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6)
Agency Negotiators: David Ziolkowski, Chief Operating Officer: California Nurse Association

Open Session

9. Report of Reportable Action(s) Taken During Closed Session, if any.
10. Adjournment

MINUTES – 5/26/10

Tab 2

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY

**Doctors Medical Center Management Authority
Governing Board Meeting
May 26, 2010 – 3:00 pm
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806**

*Governing Board
Supervisor John Gioia, Chair
Supervisor Federal G. Glover
Pat Godley
Stephen Arnold, M.D.
Bill Walker, M.D.
Beverly Wallace
Eric Zell*

Minutes

1. Call to Order and Roll Call – 3:15 p.m.

Quorum was established; roll was called.

Voting Members:

*Supervisor John Gioia, Chair
Eric Zell
Stephen Arnold, M.D.
Bill Walker, M.D.
Pat Godley*

*Excused Absence: Beverly Wallace
Supervisor Federal D. Glover*

2. Approval of Minutes - Board Meeting of April 28, 2010

The motion made by Mr. Zell and seconded by Dr. Arnold to approve the minutes of the April 28, 2010 meeting passed unanimously.

3. Public Comments

There were no public comments.

4. Quality Report

Joseph Stewart, President/CEO, made a presentation on the ORYX Core Measures to further educate the board members on the process of how they are measured and what is being done at DMC.

Following are the 4 Core Measures:

- AMI (Heart Attack)
- PNA (Pneumonia)
- CHF (Heart Failure)
- SCIP (Surgical Infection Prevention)

Actions in Place to Reach 90% Compliance:

- Patient identification on admission
- Concurrent review nurse to monitor target patients
- Tools for frontline staff
- Hospital PI Committee reviews all failures
- Performance oversight and accountability

He also provided a core measure dashboard comparing DMC core measure scores nationally; our scores range from mid 50's to low 90's.

He further explained it is important that we are in compliance because these core measures are reported to the public and have financial consequences to the hospitals as well.

5. Presentation and Acceptance of the April 2010 Financial Statements

Richard Reid, CFO, reported April 2010 net income was a gain of \$1.6 million on a budget of \$1.5 million; case mix adjusted average length of stay decreased to 3.05 days which is lower than the State average and the average daily census was 81. He reported that the total cash balance is \$17 million and there are 43 days of cash on hand.

Mr. Reid reported that RN overtime is significantly under budget for the month of April, however, registry expense is up. DMC is working with different agencies to negotiate better rates. Mr. Reid has been working with the nurse managers and registry to make sure they are making the most economic choice.

Action plans to help with the \$2 million deficit, which resulted from the operational meetings in April, were implemented. Mr. Reid will report back the results of these action plans at next month's board meeting.

The motion made by Mr. Zell and seconded by Dr. Arnold to approve the April 2010 financials passed unanimously.

6. CEO Report

Mr. Stewart reported the following:

- Three events celebrating the opening of the Outpatient Center in July are to be scheduled. They are as follows:
 - July 14, 2010, 11:30 a.m. - DMC Employees and Medical Staff Celebration & Open House
 - July 14, 2010, 5:30 p.m. – Community Stakeholder Outpatient Center Preview
 - July 24, 2010, 11:00 a.m. – Community Open House & Ribbon Cutting (tentative date)

The board members will be polled for their availability for another date to hold the community open house & ribbon cutting ceremony to make sure they are not on vacation.

- The renovation of the front entrance at DMC has begun and expected to last for another 5-6 weeks. A security staff is on duty at all times at the construction site to redirect people to the right offices.
- Mr. Stewart reported that Dr. Arnold and he met with the County regarding a Family Medicine Residency Program at DMC. This will be an extension of the existing County Residency Program. This proposal will be presented to the Medical Staff for their approval and input. If all goes well, it will take at least one year to get this project established.
- The Radiology & ER contracts are up for renewal this year. This process will be open to the existing and outside contractors. Discussion with the Medical Staff will be scheduled and a presentation will be made to the Medical Executive Committee before final selection and Board approval is sought.
- County Project Update:

The District Board held a special meeting on May 21, 2010, which served as a study session to review any remaining issues outlined in their letter of intent. In this meeting, Mr. Stewart was directed by the District Board to send the letter addressing District Board concerns, i.e., CEQA implications on the progress of the project, land lease, access, etc. The District Board continues to support the meeting of DMC management staff with County officials about acceptable plans to relocate the County clinic to DMC site.

9. Adjournment to Closed Session

The JPA Board adjourned to closed session at 4:10 p.m.

10. Report of Reportable Action Taken

There were no reportable actions taken in closed session.

FINANCIALS

MAY 2010

Tab 4



May2010 Executive Report

Doctors Medical Center had a Net Income of \$1,171,000 in the month of May. As a result, net income was over budget by \$321,000 due to higher net patient service revenue. On a year to date basis, Net income is \$5,237,000 or \$446,000 under budget. Monthly operating income was \$332,000 above budget which reduced the year to date shortfall to \$1,624,000.

The following are the factors leading to the Monthly Net Income variance:

| <u>Net Income Factors</u> | <u>Over / (Under)</u> |
|---------------------------|-----------------------|
| Net Patient Revenue | |
| Cost Report Settlements | \$874,000 |
| Outpatient Volume | (\$271,000) |
| Inpatient Volume | (\$164,000) |
| <u>Expenses</u> | |
| Salaries | (\$268,000) |
| Purchased Services | (\$78,000) |

Net patient revenue was over budget by \$439,000. DMC submitted the 2009 Medicare and Medi-Cal cost report in May. Based upon additional self pay conversions to Medi-Cal, the Medicare Disproportionate Share reimbursement increased over what was projected. Because of this increase, \$874,000 of additional Medicare income was recorded. Gross outpatient charges were under budget in May 9.6% resulting in lower reimbursement by \$271,000. Patient days were 7.0% over budget and discharges were 2.6% under budget. The increase in patient days was mainly in the self pay patients. This resulted in lower inpatient reimbursement by \$164,000.

Salaries were over budget by \$268,000. The salary variance is 5.2% which is in line with the increase in patient days of 7.0%. The increase is related to inpatient volume.

Supplies are under budget by \$164,000 due to lower surgery and cath lab volume for May.



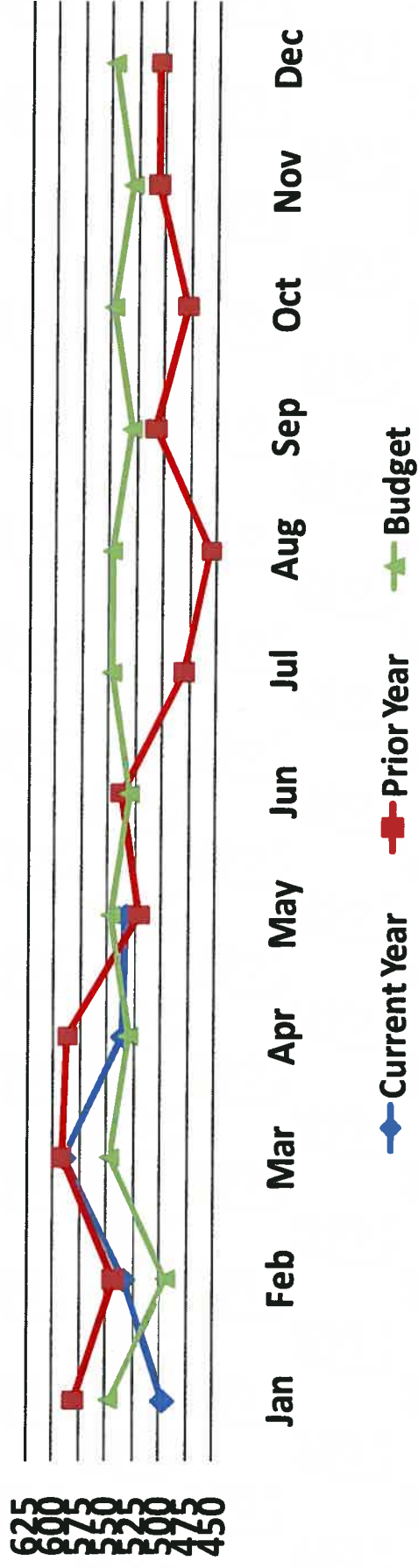
Board Presentation May 2010 Financial Report



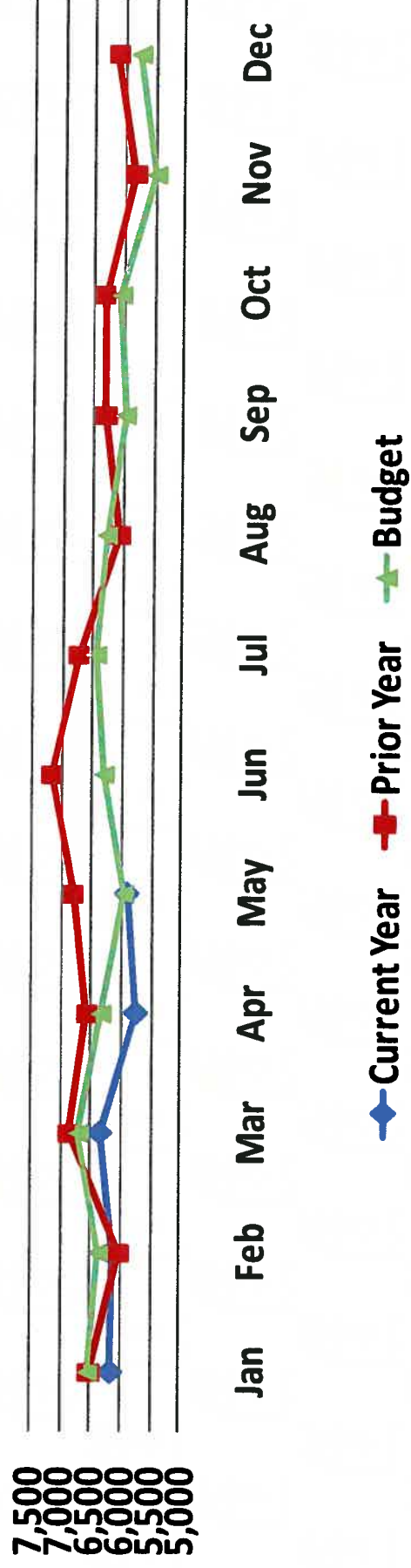
Patient Activity For the Period Ending May 31, 2010

| Actual M.T.D. | Budget M.T.D. | Variance | | Actual Y.T.D. | Budget Y.T.D. | Variance |
|------------------|------------------|----------|----------------------|------------------|------------------|----------|
| 533 | 547 | (14) | Inpatient Discharges | 2,689 | 2,666 | 23 |
| 5,917 | 5,970 | (53) | Outpatient Visits | 30,340 | 31,962 | (1,622) |

Inpatient Discharges



Outpatient Visits



Statement of Activity – Summary

For the Period Ending

May 31, 2010

(Thousands)

| Actual M.T.D. | Budget M.T.D. | Variance | | Actual Y.T.D. | Budget Y.T.D. | Variance |
|------------------|------------------|----------|-------------------------------|------------------|------------------|-----------|
| \$10,976 | \$10,528 | \$448 | Net Operating Revenues | \$53,979 | \$54,679 | (\$700) |
| \$11,866 | \$11,750 | (\$116) | Total Operating Expenses | \$60,277 | \$59,353 | (\$924) |
| (\$890) | (\$1,222) | \$332 | Income/(Loss) From Operations | (\$6,298) | (\$4,674) | (\$1,624) |
| \$2,061 | \$2072 | (\$11) | Income from Other Sources | \$11,535 | \$10,357 | \$1,178 |
| \$1,171 | \$850 | \$321 | Net Income/(Loss) | \$5,237 | \$5,683 | (\$446) |
| 10.7% | 8.1% | 2.6% | Net Income Percentage | 9.7% | 10.4% | -0.7% |
| | | | California Benchmark Average | 2.1% | | |
| | | | Top 25% | 7.1% | | |
| | | | Top 10% | 11.5% | | |

Budget Variances – Net Revenue

- Cost Report Submissions – Increase in Medicare Disproportionate Share Reimbursement due to high volume of Self Pay conversions to Medi-Cal \$874,000
- Outpatient Revenue Down by 9.6% – (\$271,000)
 - Radiation Therapy , CT Scans and Cath Lab
- Inpatient Cases down by 14 and increase in Self Pay Up – (\$164,000)

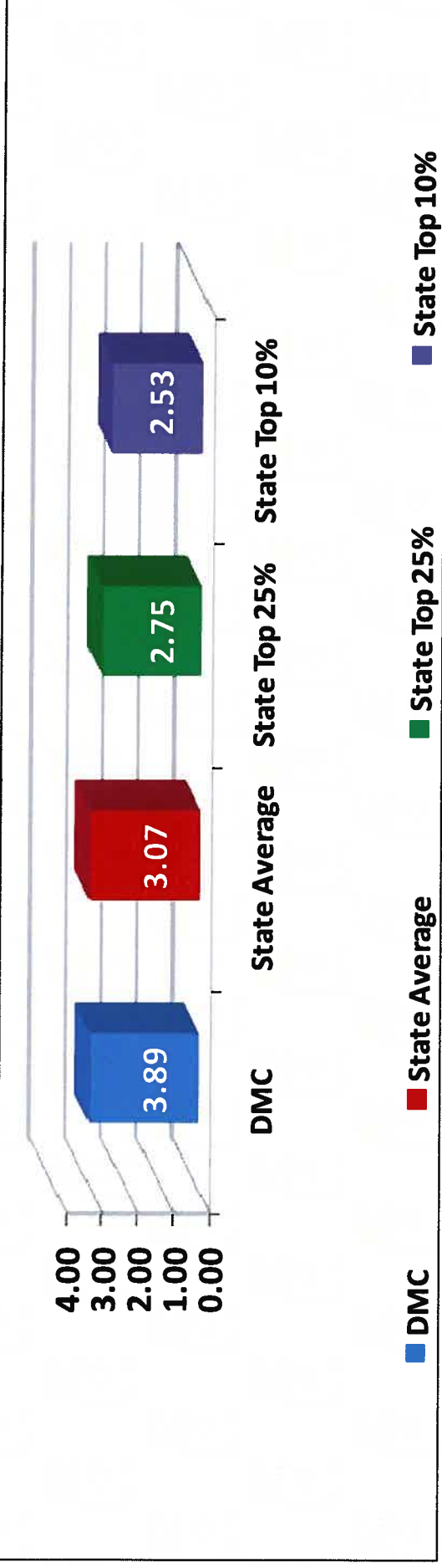


Budget Variances – Expenses

- ▶ Salaries – (\$268,000) or 5.2%
 - Inpatient Days over budget by 7% – Variance is volume related
- ▶ Supplies – \$164,000
 - Due to lower volume of Ortho Implants and Pacemakers

Length of Stay Comparison Adjusted For Case Mix Index

May



YTD



Cash Position

May 31, 2010

(Amounts in Thousands)

| | May 31, 2010 | December 31, 2009 |
|------------------------------|--------------|-------------------|
| Unrestricted Cash | \$5,764 | \$7,666 |
| Restricted Cash | \$6,166 | \$5,363 |
| Total Cash | \$11,930 | \$13,029 |
| Days Unrestricted Cash | 15 | 21 |
| Days Restricted | 16 | 14 |
| Total Days of Cash | 31 | 35 |
| California Benchmark Average | 34 | |
| Top 25% | 82 | |
| Top 10% | 183 | |

Accounts Receivable

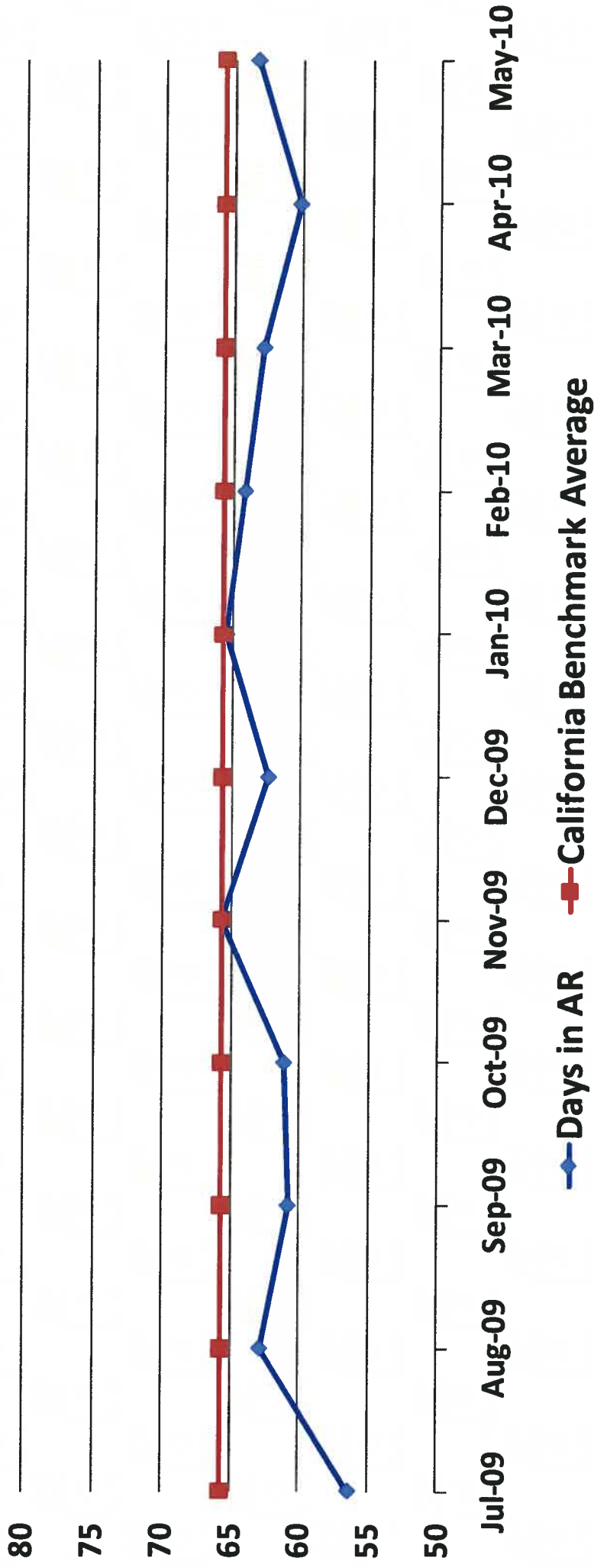
May 31, 2010

(Amounts in Thousands)

| | May 31, 2010 | December 31, 2009 |
|---------------------------------|--------------|-------------------|
| Net Patient Accounts Receivable | \$22,894 | \$19,157 |
| Net Days in Accounts Receivable | 63.3 | 62.3 |
| California Benchmark Average | 65.7 days | |
| Top 25% | 45.2 days | |
| Top 10% | 35.5 days | |

Accounts Receivable

Net Days in AR



Action Plan Update

- ▶ Identified over \$2 million in Revenue and Cost Reduction Opportunities
- ▶ Achieved Savings
 - Revenue Increases \$66,000
 - Cost Reductions \$11,000
 - Total Benefit to date \$77,000



Questions



**WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
May 31, 2010
(Amounts in Thousands)**

| | CURRENT PERIOD | | | CURRENT YTD | | | PRIOR YEAR | |
|--|----------------|---------|-------|-------------|---------|---------|------------|---------|
| | ACTUAL | BUDGET | VAR | VAR % | ACTUAL | BUDGET | VAR | ACTUAL |
| 1 | 10,875 | 10,436 | 439 | 4.2% | 53,542 | 54,216 | (674) | 52,314 |
| 2 | 101 | 92 | 9 | 9.8% | 437 | 463 | (26) | 432 |
| 3 | 10,976 | 10,528 | 448 | 4.3% | 53,979 | 54,679 | (700) | 52,746 |
| OPERATING REVENUE | | | | | | | | |
| Net Patient Service Revenue | | | | | | | | |
| Other Revenue | | | | | | | | |
| Total Operating Revenue | | | | | | | | |
| 4 | 5,430 | 5,162 | (268) | -5.2% | 26,989 | 26,477 | (512) | 27,527 |
| 5 | 2,574 | 2,639 | 65 | 2.5% | 13,307 | 13,325 | 18 | 11,443 |
| 6 | 769 | 781 | 12 | 1.5% | 4,102 | 3,905 | (197) | 3,731 |
| 7 | 1,506 | 1,670 | 164 | 9.8% | 8,543 | 8,138 | (405) | 8,368 |
| 8 | 781 | 703 | (78) | -11.1% | 3,517 | 3,515 | (2) | 2,921 |
| 9 | 161 | 123 | (38) | -30.9% | 737 | 615 | (122) | 458 |
| 10 | 297 | 300 | 3 | 1.0% | 1,464 | 1,522 | 58 | 1,445 |
| 11 | 348 | 372 | 24 | 6.5% | 1,618 | 1,858 | 238 | 1,710 |
| 12 | 11,886 | 11,750 | (136) | -1.0% | 60,277 | 59,353 | (924) | 57,603 |
| OPERATING EXPENSES | | | | | | | | |
| Salaries & Wages | | | | | | | | |
| Employee Benefits | | | | | | | | |
| Professional Fees | | | | | | | | |
| Supplies | | | | | | | | |
| Purchased Services | | | | | | | | |
| Rentals & Leases | | | | | | | | |
| Depreciation & Amortization | | | | | | | | |
| Other Operating Expenses | | | | | | | | |
| Total Operating Expenses | | | | | | | | |
| Operating Profit / Loss | | | | | | | | |
| 13 | (890) | (1,222) | 332 | -27.2% | (6,288) | (4,674) | (1,624) | (4,857) |
| NON-OPERATING REVENUES (EXPENSES) | | | | | | | | |
| Other Non-Operating Revenue | | | | | | | | |
| District Tax Revenue | | | | | | | | |
| Investment Income | | | | | | | | |
| Less: Interest Expense | | | | | | | | |
| Total Net Non-Operating | | | | | | | | |
| Income Profit (Loss) | | | | | | | | |
| 14 | 1,416 | 1,417 | (1) | 0.1% | 8,311 | 7,081 | 1,230 | 5,500 |
| 15 | 753 | 771 | (18) | 2.3% | 3,765 | 3,855 | (90) | 3,813 |
| 16 | 8 | 9 | (1) | -11.1% | 47 | 42 | 5 | 47 |
| 17 | (116) | (125) | 9 | 0.0% | (588) | (621) | 33 | (657) |
| 18 | 2,081 | 2,072 | (9) | -0.5% | 11,535 | 10,357 | 1,178 | 8,703 |
| 19 | 1,171 | 850 | 321 | 37.8% | 5,237 | 5,683 | (446) | 3,846 |
| Profitability Ratios: | | | | | | | | |
| Operating Margin % | -8.1% | -11.6% | | | -11.7% | -8.5% | | -9.2% |
| Profit Margin % | 10.7% | 8.1% | | | 9.7% | 10.4% | | 7.3% |

**WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT**

May 31, 2010

(Amounts in Thousands)

| | | | | | | | | | | | |
|----|---------------|---------------|--------------|--------------|---------------|--------------------------------|----------------|----------------|-----------------|--------------|----------------|
| 22 | 1,970 | 1,968 | (4) | -0.2% | 1,941 | SWB / APD | 1,940 | 1,957 | 17 | 0.8% | 2,024 |
| 23 | 67.5% | 66.4% | | | 66.3% | SWB / Total Operating Expenses | 66.9% | 67.1% | | | 67.7% |
| 24 | 2,921 | 2,961 | 40 | 1.4% | 2,927 | Total Operating Expenses / APD | 2,902 | 2,918 | 18 | 0.5% | 2,991 |
| 25 | 40,999 | 39,532 | 1,467 | 3.7% | 38,281 | I/P Gross Charges | 202,590 | 205,301 | (2,711) | -1.3% | 201,900 |
| 26 | 18,001 | 19,913 | (1,912) | -9.6% | 19,917 | O/P Gross Charges | 91,899 | 102,039 | (10,140) | -9.9% | 96,269 |
| 27 | <u>69,000</u> | <u>59,445</u> | <u>(445)</u> | <u>-0.7%</u> | <u>57,898</u> | <u>Total Gross Charges</u> | <u>294,489</u> | <u>307,339</u> | <u>(12,850)</u> | <u>-4.2%</u> | <u>288,169</u> |

Payor Mix (I/P and OP)

| | | | | | | | | | |
|----|-----|-----|-----|-----|--------------------------|-----|-----|-----|-----|
| 28 | 36% | 39% | -3% | 38% | Medicare % | 38% | 39% | -1% | 38% |
| 29 | 17% | 17% | 0% | 16% | Medi-Cal % | 17% | 17% | 0% | 16% |
| 30 | 14% | 15% | -1% | 16% | Managed Care HMO / PPO % | 14% | 15% | -1% | 16% |
| 31 | 8% | 11% | -3% | 11% | Medicare HMO % | 10% | 11% | -1% | 11% |
| 32 | 7% | 6% | 1% | 6% | Medi-Cal HMO % | 7% | 6% | 1% | 6% |
| 33 | 0% | 0% | 0% | 0% | Commercial % | 0% | 0% | 0% | 0% |
| 34 | 1% | 1% | 0% | 1% | Worker's Comp % | 2% | 1% | 1% | 1% |
| 35 | 4% | 4% | 0% | 5% | Other Government % | 3% | 4% | -1% | 4% |
| 36 | 13% | 7% | 6% | 7% | Self Pay /Charity % | 10% | 7% | 3% | 8% |

STATISTICS

| | | | | | | | | | | | |
|----|------------|------------|-------------|---------------|------------|------------------------------|------------|--------------|--------------|---------------|------------|
| 37 | 544 | 548 | (2) | -0.3% | 523 | Admissions | 2,698 | 2,659 | 39 | 1.5% | 2,808 |
| 38 | 533 | 547 | (14) | -2.6% | 521 | Discharges | 2,689 | 2,686 | 23 | 0.9% | 2,823 |
| 39 | 2,823 | 2,639 | 184 | 7.0% | 2,599 | Patient Days | 14,288 | 13,588 | 700 | 5.2% | 13,040 |
| 40 | 91.1 | 85.1 | 5.9 | 7.0% | 83.8 | Average Daily Census (ADC) | 94.6 | 90.0 | 4.6 | 5.2% | 86.4 |
| 41 | 5.30 | 4.82 | (0.47) | -9.8% | 4.99 | Average Length of Stay (LOS) | 5.31 | 5.10 | (0.22) | -4.2% | 4.62 |
| 42 | 31 | 31 | | | 31 | Days in Month | 151 | 151 | | | 151 |
| 43 | 767 | 823 | (56) | -6.8% | 788 | Adjusted Discharges (AD) | 3,909 | 3,991 | (82) | -2.1% | 4,169 |
| 44 | 4,062 | 3,968 | 94 | 2.4% | 3,931 | Adjusted Patient Days (APD) | 20,769 | 20,342 | 428 | 2.1% | 19,258 |
| 45 | 131 | 128 | 3 | 2.4% | 127 | Adjusted ADC (AADC) | 138 | 135 | 3 | 2.1% | 128 |
| 46 | 80 | 92 | (12) | -13.0% | 93 | Inpatient Surgeries | 440 | 496 | (56) | -11.3% | 469 |
| 47 | 80 | 104 | (24) | -23.1% | 96 | Outpatient Surgeries | 457 | 562 | (105) | -18.7% | 514 |
| 48 | <u>160</u> | <u>196</u> | <u>(36)</u> | <u>-18.4%</u> | <u>189</u> | <u>Total Surgeries</u> | <u>897</u> | <u>1,059</u> | <u>(161)</u> | <u>-15.2%</u> | <u>983</u> |

**WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT**

May 31, 2010

(Amounts in Thousands)

| | | | | | | | | | | | |
|----|--------------|--------------|-------------|--------------|--------------|--------------------------------|---------------|---------------|----------------|--------------|---------------|
| 49 | 2,858 | 2,885 | (127) | -4.3% | 3,172 | ED Outpatient Visits | 14,841 | 18,231 | (1,390) | -8.6% | 14,686 |
| 50 | 2,979 | 2,881 | 98 | 3.4% | 3,107 | Ancillary Outpatient Visits | 15,042 | 15,169 | (127) | -0.8% | 15,193 |
| 51 | 80 | 104 | (24) | -23.1% | 96 | Outpatient Surgeries | 457 | 562 | (105) | -18.7% | 514 |
| 52 | <u>5,917</u> | <u>5,970</u> | <u>(53)</u> | <u>-0.9%</u> | <u>6,375</u> | <u>Total Outpatient Visits</u> | <u>30,340</u> | <u>31,962</u> | <u>(1,622)</u> | <u>-5.1%</u> | <u>30,373</u> |
| 53 | 450 | 453 | (3) | -0.7% | 475 | Emergency Room Admits | 2,322 | 2,423 | (101) | -4.2% | 2,395 |
| 54 | 15.7% | 15.2% | | | 15.0% | % of Total E/R Visits | 15.6% | 14.9% | | | 16.3% |
| 55 | 82.7% | 83.0% | | | 90.8% | % of Acute Admissions | 86.1% | 91.1% | | | 85.4% |
| 56 | 617 | 593 | 24 | 4.0% | 634 | Worked FTE | 617 | 625 | (8) | -1.3% | 617 |
| 57 | 714 | 685 | 29 | 4.2% | 697 | Paid FTE | 697 | 719 | (22) | -3.1% | 692 |
| 58 | 4.71 | 4.63 | 0.08 | 1.8% | 5.00 | Worked FTE / AADC | 4.49 | 4.66 | (0.17) | -3.7% | 4.84 |
| 59 | 5.45 | 5.35 | 0.10 | 1.8% | 5.50 | Paid FTE / AADC | 5.06 | 5.37 | (0.30) | -5.7% | 5.43 |
| 60 | 2,677 | 2,630 | 47 | 1.8% | 2,551 | Net Patient Revenue / APD | 2,578 | 2,665 | (87) | -3.3% | 2,717 |
| 61 | 14,523 | 14,980 | (457) | -3.0% | 14,729 | I/P Charges / Patient Days | 14,179 | 15,109 | (930) | -6.2% | 15,483 |
| 62 | 3,042 | 3,336 | (293) | -8.8% | 3,077 | O/P Charges / Visit | 3,029 | 3,193 | (164) | -5.1% | 3,170 |
| 63 | 1,337 | 1,301 | (36) | -2.8% | 1,349 | Salary Expense / APD | 1,289 | 1,302 | 2 | 0.2% | 1,429 |
| 64 | 5.3 | 5.0 | (0.27) | -5.4% | 5.0 | Medicare LOS | 5.6 | 4.7 | (0.88) | -18.4% | 4.7 |
| 65 | 1.45 | 1.54 | 0.09 | 5.8% | 1.54 | Medicare CMI | 1.62 | 1.55 | (0.07) | -4.7% | 1.55 |
| 66 | 3.63 | 3.24 | (0.39) | -11.9% | 3.24 | Medicare CMI Adjusted LOS | 3.47 | 3.07 | (0.40) | -13.1% | 3.07 |
| 67 | 5.3 | 4.8 | (0.48) | -9.9% | 5.0 | Total LOS | 5.3 | 5.1 | (0.23) | -4.4% | 4.83 |
| 68 | 1,361 | 1,486 | 0.12 | 8.4% | 1,468 | Total CMI | 1,525 | 1,500 | (0.02) | -1.6% | 1,500 |
| 69 | 3.89 | 3.24 | (0.65) | -20.0% | 3.36 | Total CMI Adjusted LOS | 3.50 | 3.40 | (0.09) | -2.8% | 3.09 |

**WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
May 31, 2010
(Amounts in \$1,000)**

| ASSETS | Current Month | Dec. 31, 2009 | LIABILITIES | Current Month | Dec. 31, 2009 |
|---|----------------------|----------------------|--|----------------------|----------------------|
| 67 Cash | 5,764 | 7,666 | 93 Current Maturities of Debt Borrowings | 3,690 | 3,634 |
| 68 Net Patient Accounts Receivable | 22,894 | 19,157 | 94 Accounts Payable and Accrued Expenses | 14,800 | 11,827 |
| 69 Other Receivables | 7,886 | 5,367 | 95 Accrued Payroll and Related Liabilities | 10,767 | 9,403 |
| 70 Inventory | 2,189 | 2,056 | 96 Deferred District Tax Revenue | 2,160 | 3,570 |
| 70 Current Assets With Limited Use | 5,524 | 4,721 | 97 Estimated Third Party Payor Settlements | 2,718 | 3,471 |
| 71 Prepaid Expenses and Deposits | 1,197 | 610 | | | |
| 72 TOTAL CURRENT ASSETS | 45,454 | 39,577 | 98 Total Current Liabilities | 34,135 | 31,905 |
| 73 Assets With Limited Use | 842 | 842 | Other Liabilities | | |
| Property Plant & Equipment | | | 99 Other Deferred Liabilities | 0 | 0 |
| 74 Land | 12,090 | 12,090 | 100 Chapter 9 Bankruptcy | 1,771 | 1,771 |
| 75 Bldg/Leasehold Improvements | 34,974 | 34,390 | Long Term Debt | | |
| 76 Capital Leases | 10,926 | 10,926 | 101 Notes Payable - Secured | 25,391 | 25,966 |
| 77 Equipment | 33,462 | 32,889 | 102 Capital Leases | 2,259 | 2,973 |
| 78 CIP | 1,827 | 1,281 | 103 Less Current Portion LTD | -3,690 | -3,633 |
| 79 Total Property, Plant & Equipment | 93,279 | 91,576 | 104 Total Long Term Debt | 23,960 | 25,306 |
| 80 Accumulated Depreciation | -48,985 | -47,543 | | | |
| 81 Net Property, Plant & Equipment | 44,294 | 44,033 | 105 Total Liabilities | 59,866 | 58,982 |
| 82 Intangible Assets | 568 | 586 | EQUITY | | |
| | | | 106 Retained Earnings | 25,855 | 14,807 |
| | | | 107 Year to Date Profit / (Loss) | 5,237 | 11,049 |
| | | | 108 Total Equity | 31,092 | 25,856 |
| 83 Total Assets | 90,958 | 84,838 | 109 Total Liabilities & Equity | 90,958 | 84,838 |
| 84 Current Ratio (CA/CL) | 1.33 | 1.24 | | | |
| 85 Net Working Capital (CA-CL) | 11,319 | 7,672 | | | |
| 86 Long Term Debt Ratio (LTD/TA) | 0.26 | 0.30 | | | |
| 87 Long Term Debt to Capital (LTD/(LTD+TE)) | 0.44 | 0.49 | | | |
| 88 Financial Leverage (TA/TE) | 2.9 | 3.3 | | | |
| 89 Quick Ratio | 0.84 | 0.84 | | | |
| 90 Unrestricted Cash Days | 15 | 21 | | | |
| 91 Restricted Cash Days | 16 | 14 | | | |
| 92 Net A/R Days | 63.3 | 62.3 | | | |

Paragon Information System

Tab 5

**DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM**

TO: DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY

FROM: David Ziolkowski, COO

DATE: June 23, 2010

SUBJECT: McKesson Paragon Hospital Information System Installation

REQUEST / RECOMMENDATION(S): Recommend to the West Contra Costa County District Board to approve and authorize the Chief Operating Officer, or designee, to execute on behalf of DMC, a contract with McKesson for the installation of Paragon Health Information System.

FISCAL IMPACT: \$2,400,000

The cost of the project will be approximately \$2.4 Million cost for the Paragon installation spread over 18 months. The project was budgeted for in the 2010 capital budget and planned for in the 2011 capital budget.

STRATEGIC IMPACT: With implementation of an electronic health record, numerous benefits help improve the operations and quality of care provided at DMC. Key benefits of the Paragon include:

- Improve medication safety
- Utilization of evidence-based best practices
- Increase revenue cycle
- Improve employee productivity

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: The cost of the project will be approximately \$2.4 Million cost for the Paragon installation spread over 18 months. Completion of the projects allows DMC to access roughly \$5,000,000 in government incentives starting in 2012. Paragon provides the lowest cost alternative to gain \$5,000,000 incentive and will ultimately reduction our current operating costs. Paragon is being rapidly adopted in California and has great references. Paragon is a simple to use / turnkey solution, runs on a single integrated database and requires no interfaces to support the core system. No additional staff are required to support the system once implemented.

Presentation Attachments: Yes X No

Requesting Signature: _____ Date: / /

SIGNATURE(S):

Action of Board on / / Approved as Recommended Other

Vote of Board Members:

 Unanimous (Absent)

Ayes: Noes:

Absent: Abstain:

| |
|---|
| I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN. |
|---|

Contact Person: Richard Reid

Attested _____
Eric Zell, Management Authority Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

DMC Information Systems Project

Doctors Medical Center
Management Authority, JPA Board
West Contra Costa County
Healthcare Distinct Board
June 23, 2010

Introduction to President Obama's Stimulus Package for Healthcare IT

- Signed February 17, 2009 amidst a global wave of stimulus spending
- Aimed at pulling the U.S. economy from recession
- Plan will stimulate vital sectors of the economy such as energy and health care, making U.S. firms more competitive

Introduction to President Obama's Stimulus Package for Healthcare IT

- There are roughly \$505 billion on new projects and about \$282 billion in tax cuts
- In Healthcare, the bill includes:
 - \$87 billion for Medicaid
 - \$20 billion to improve health information technology
 - \$10 billion for health research and construction of facilities for the National Institutes of Health

Government's Goal – “Meaningful Use”

| Health Outcomes Policy Priority | Care Goals |
|--|--|
| Improving quality, safety, efficiency, and reducing health disparities | <ul style="list-style-type: none"> • Provide access to comprehensive patient health data for patient's healthcare team • Use evidence-based order sets and CPOE • Apply clinical decision support at the point of care • Generate lists of patients who need care and use them to reach out to patients • Report information for quality improvement and public reporting |
| Engage patients and families in their health care | <ul style="list-style-type: none"> • Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health |
| Improve care coordination | <ul style="list-style-type: none"> • Exchange meaningful clinical information among professional health care team |
| Improve population and public health | <ul style="list-style-type: none"> • Communicate with public health agencies |
| Ensure adequate privacy and security protections for personal health information | <ul style="list-style-type: none"> • Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law • Provide transparency of data sharing to patient |

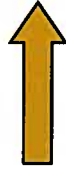
Source: Excerpt of TABLE 2: Stage 1 Criteria for Meaningful Use. U.S. Department of Health & Human Services. *Medicare and Medicaid Programs; Electronic Health Record Incentive Program*. Vol. 75, No. 8. / Federal Register / page 1867 / January 13, 2010 / Proposed Rules. Retrieved January 14, 2010, from <http://www.gpoaccess.gov/fr/index.html>

Meaningful Use Stages

Stage

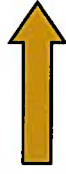
Goal

Stage 1 (formerly 2011)



Electronic Capture of Patient Data

Stage 2 (formerly 2013)



Improved Clinical Processes

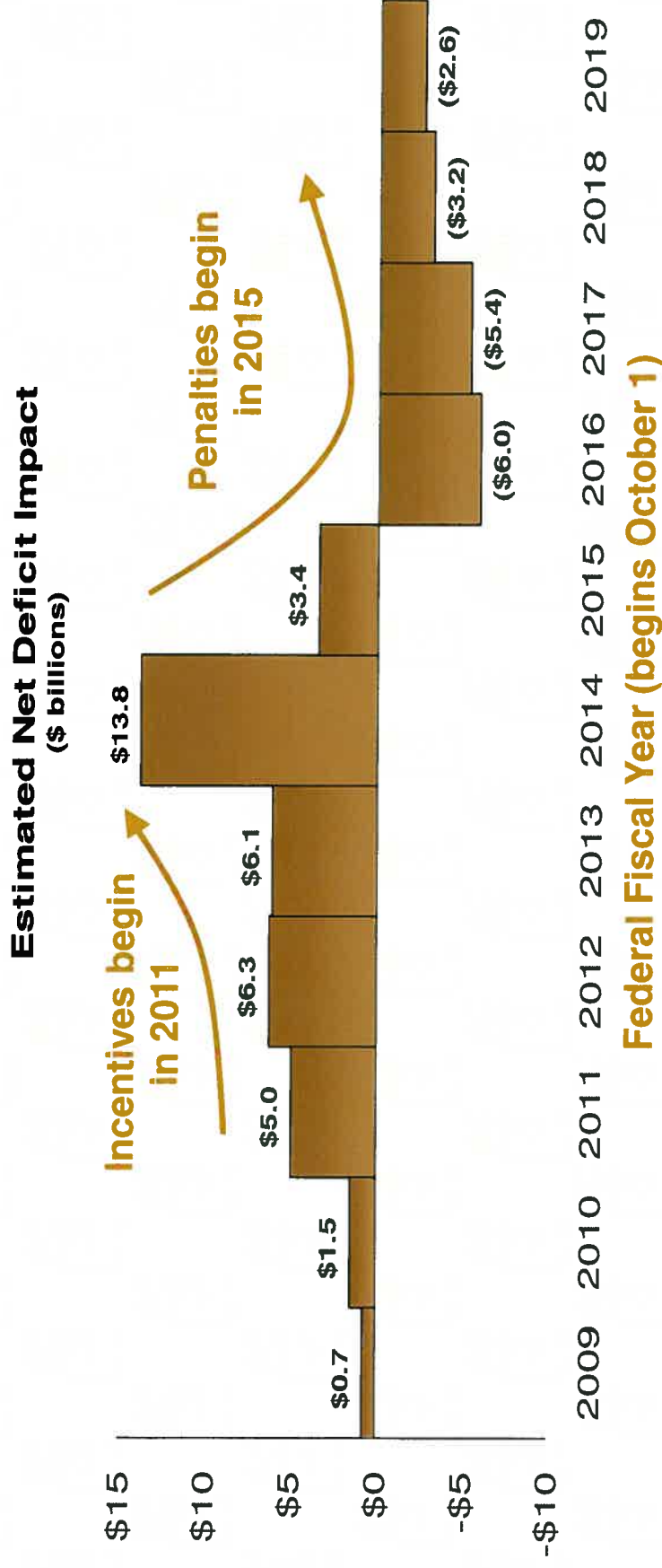
Stage 3 (formerly 2015)



Quality Measurement and Improvement

- ▶ Proposed updating meaningful use criteria on a biennial basis (NPRM, pg 1852):
 - Stage 2 proposed by end of CY 2011
 - Stage 3 proposed by end of CY 2013
- ▶ Clear indication Stage 3 will not be last year of requirements

Government's Plan



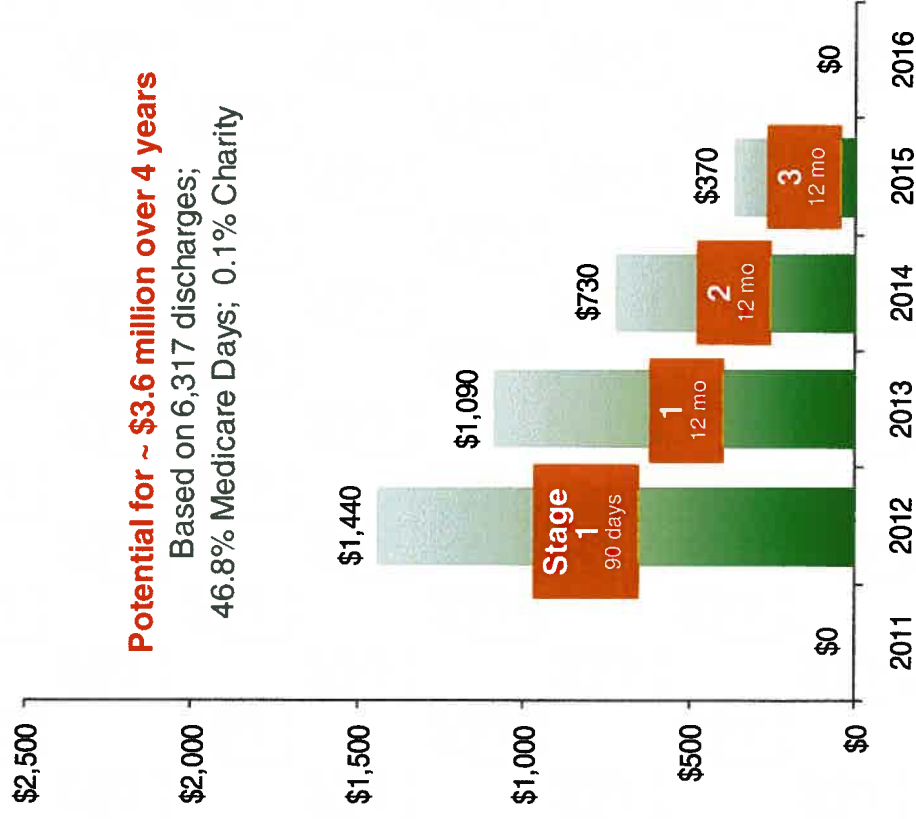
► **Funding utilizes both a “carrot” and “stick”**

- \$19 billion total, including:
 - \$36 billion incentive payments for use of healthcare IT begin in 2011
 - \$17 billion penalties for non-compliance begin in 2015

DMC “Carrot”

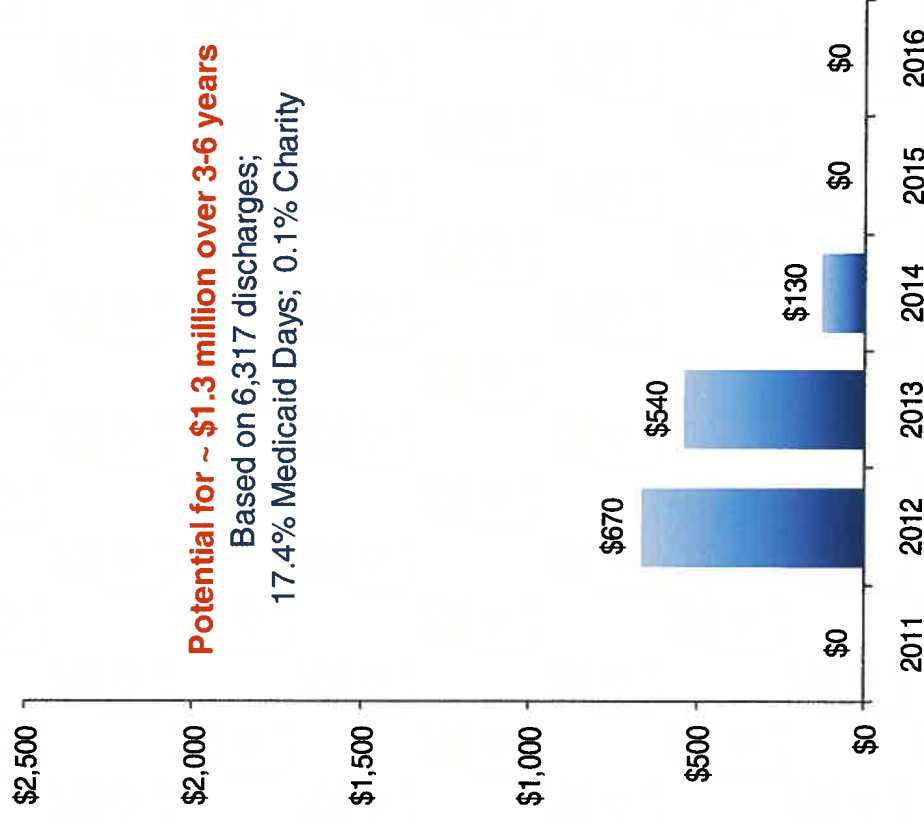
Potential Hospital Incentive - Medicare (thousands)

Potential for ~ \$3.6 million over 4 years
Based on 6,317 discharges;
46.8% Medicare Days; 0.1% Charity



Potential Hospital Incentive - Medicaid (thousands)

Potential for ~ \$1.3 million over 3-6 years
Based on 6,317 discharges;
17.4% Medicaid Days; 0.1% Charity



DMC “Stick”

■ Non-compliance of EHR requirements results in penalties

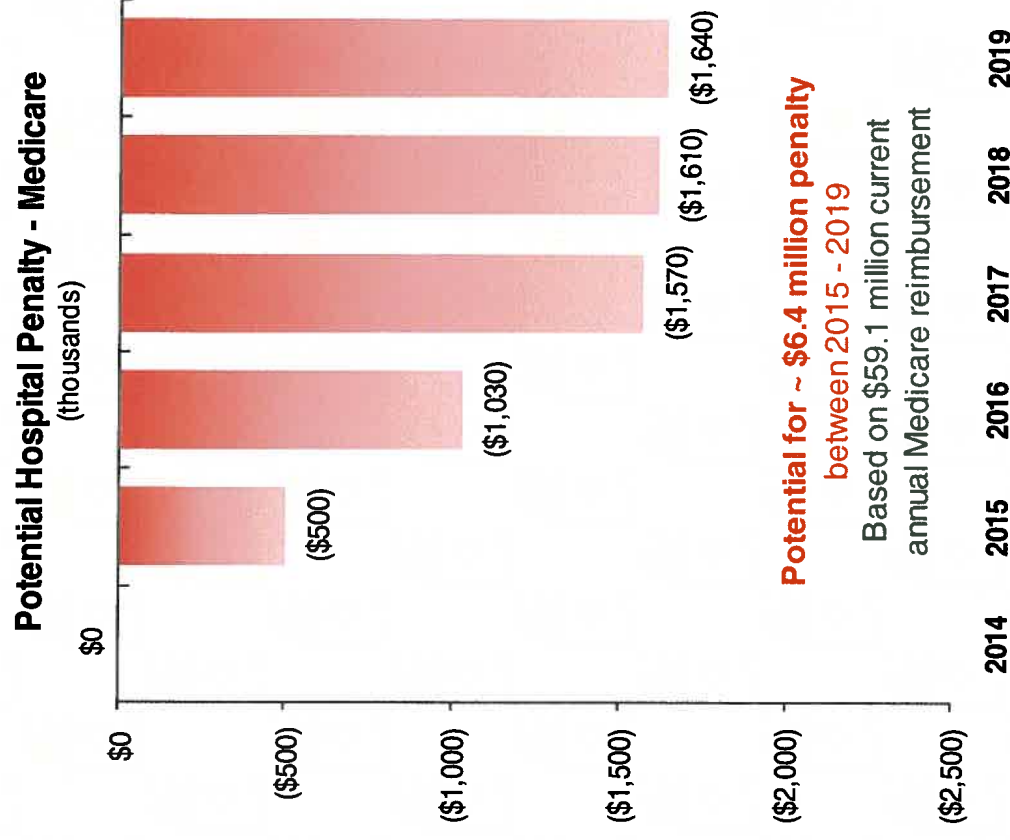
- Penalties begin in FY 2015
- Impacts Medicare only – not Medicaid

■ Penalized through reductions in market basket adjustments

- FY 2015 – 25% cut in applicable increase
- FY 2016 – 50% cut
- FY 2017 and beyond – 75% cut

■ Projections based on historical national average market basket adjustment of 3.1%

- FY 2015: $3.1\% \times 25\% = 0.775\%$ penalty
- FY 2016: $3.1\% \times 50\% = 1.550\%$ penalty
- FY 2017⁺: $3.1\% \times 75\% = 2.325\%$ penalty



How does DMC get \$5,000,000 incentive?

- DMC proposes to fund and implement two Information System projects to meet Stage 1 criteria for full incentive payment by 12-31-2011
- DMC also has 6 months to meet Stage 2 criteria by 7-1-2012
 - Stage 2 criteria is not defined as of yet
- Industry experts believe ALL dates to meet meaningful use criteria will be pushed back

DMC Options

DMC completed a Readiness Assessment to identify gaps at the hospital to achieve HIT meaningful use

1. Expand functionality & modules of existing McKesson Horizon System
2. Migrate to McKesson Paragon software platform
3. Convert to completely new software platform from a new company (Meditech)

Costs of Options

| | McKesson Horizon (Existing) | McKesson Paragon | Meditech |
|--------------------------------|-----------------------------------|---------------------|--------------|
| Purchase/Implementation | \$ 5,750,000 | \$ 2,400,000 | \$ 6,500,000 |
| Annual Maintenance / Upgrades* | \$ 1,500,000 | \$ 675,000 | \$ 550,000 |
| Incremental IT Staff | 8 | 0 | 0 |
| Incremental IT Staff Costs | \$ 760,000 | - | - |
| 5 Year Total Costs | \$ 17,050,000 | \$ 5,775,000 | \$ 9,250,000 |

All 3 options require \$250,000 in internal staff costs in 2010 and \$ \$500,000 internal staff costs in 2011

* Current annual Horizon maintenance and upgrades are ~\$900,000

Why Paragon?

- Lowest cost alternative to gain \$5,000,000 incentive
- Reduction in operating costs
- Great references, nursing endorsement
- Large & growing presence in California
- No fees for upgrades
- Simple to use / turnkey solution
- Single database, no interfaces
- No additional staff to support

Required Resources

| Resource Requirements - by Product Group | | | | | | | | | | | | | | | | | | | |
|--|-------|--------------------------------|--|----|----|-----|-----|-----|-------|------|-------|-------|------|------|-------|-------|-------|-------|------|
| Product | Group | Resource Desc | Name | -2 | -1 | 1 | 2 | 3 | Start | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 14 | 15 | Live |
| Program Management | IT | Program Manager | Guy Tennyson / Phyllis Moore | | | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | |
| Program Management | | | | | | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | |
| Paragon | DEPT | Patient Accounting | Candy Martinez | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Paragon | DEPT | Registration | Andy Torres | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Paragon | DEPT | Orders/Results | Beth Frizell | | | | | | | 0.82 | 0.82 | 0.82 | 0.82 | 0.82 | 0.82 | 0.82 | 0.82 | 0.82 | |
| Paragon | DEPT | GL/AP | Jim Boatman | | | | | | | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | |
| Paragon | DEPT | Fixed Assets | Jim Boatman | | | | | | | | | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | |
| Paragon | DEPT | Medical Records | Jody Popke | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Paragon | IT | Print Services / Forms Routing | System Admin/ Analyst | | | | | | | | | 1 | 0.13 | 0.13 | 0.13 | 0.13 | 0.13 | 0.13 | |
| Paragon | DEPT | Claims | Candy Martinez | | | | | | | | | | 0.35 | 0.35 | 0.35 | 0.35 | 0.35 | 0.35 | |
| Paragon | DEPT | Materials Management | Carl Hanserd / Jennifer Viramontes | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Paragon | DEPT | Supply Charging | Carl Hanserd / Central Supply | | | | | | | | | | | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | |
| Paragon | DEPT | Radiology | Shirley Tillman-Walker / Ian McWilliam | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Paragon | DEPT | Scheduling | Shirley Tillman-Walker / Carla Knight / IT Analyst | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Paragon | DEPT | Pharmacy | Kerry Iwatus | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Paragon | DEPT | Med Admin | Pharmacy - Moved to Phase II | | | | | | | | | | | | 0.08 | 0.08 | 0.08 | 0.08 | |
| Paragon | DEPT | Care Plans & Assessments | Sean McNeal - Education / Nursing | | | | | | | | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | |
| Paragon | DEPT | Surgery | Carla Knight / Beth Frizell | | | | | | | | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | |
| Paragon | DEPT | Emergency Department | ED Director | | | | | | | | | | | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | |
| Paragon | DEPT | Physician Web | David Ziolkowski / Dr. Cadotte | | | | | | | | | | | | 0.08 | 0.08 | 0.08 | 0.08 | |
| Paragon | IT | Database Administrator | IT DBA | | | | | | | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | |
| Paragon | IT | Interface Analyst | IT Interface Specialist | | | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | |
| Paragon | IT | Conversion Analyst | IT Analysts | | | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | |
| Paragon | IT | Project Manager | Guy Tennyson / Phyllis Moore | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Paragon | IT | System Administrator | IT System Admin | | | | | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | 0.7 | |
| Paragon Total | | | | 0 | 0 | 2.4 | 2.4 | 3.1 | | 8.72 | 18.72 | 19.92 | 19.4 | 20.4 | 20.56 | 20.56 | 20.56 | 20.56 | |

Summary / Recommendations

- Paragon is the best option for DMC to achieve meaningful use and \$5,000,000 of incentive payments
- Implement Paragon 12-month Phase 1 project in July 2010
- Implement 6-month Phase 2 project in July 2011
- Obtain Stage 1 Meaningful Use payment in Q1 2012

■ Exhibit A: Paragon Meaningful Use Mapping

Meaningful Use Criteria

| Stage 1 Objectives/Measures | Phase 1 Products | Additional Paragon Products Required |
|---|--|--|
| 1. Use of CPOE for all order types. • Measure: For 10% of all orders. | WebStation for Physicians Order Management Pharmacy Management | ● CPOE - Phase 2 |
| 2. Implement drug-drug, drug-allergy, and drug formulary checks. • Measure: Enabled functionality. | WebStation for Physicians Pharmacy Management | ● CPOE - Phase 2 |
| 3. Maintain an up-to-date problem list of current/active diagnoses based on ICD-9-CM/SNOMED CT. • Measure: At least 80% of admitted patients have one entry or "none" recorded as structured data. | WebStation for Physicians <i>and either</i> Order Management <i>or</i> Clinical CareStation | ● |
| 4. Maintain active medication list. • Measure: Same as above. | Pharmacy Management <i>and either</i> Order Management <i>or</i> Clinical CareStation | ● |
| 5. Maintain active medication allergy list. • Measure: Same as above. | Pharmacy Management <i>and either</i> Order Management <i>or</i> Clinical CareStation | ● |

Meaningful Use Criteria

| Stage 1 Objectives/Measures | Phase 1 Products | Additional Paragon Products Required |
|---|---|--|
| 6. Record demographics: preferred language, insurance type, gender, race, ethnicity, date of birth, date and cause of death in the event of mortality. <ul style="list-style-type: none"> • Measure: Same as above. | Registration | ● |
| 7. Record and chart changes in vital signs: Ht/Wt; BP; calculate/display BMI; plot/display growth charts for children 2-20 years, including BMI. <ul style="list-style-type: none"> • Measure: Same as above. | Clinical Carestation or Physician Documentation (post 10.0) | ● CPOE – Phase 2 |
| 8. Record smoking status for patients > = 13 years old. <ul style="list-style-type: none"> • Measure: Same as above. | Clinical Carestation or Registration | ● |
| 9. Incorporate lab test results into EHR as structured data. <ul style="list-style-type: none"> • Measure: At least 50% of all ordered lab tests (with either positive/negative or numerical result formats). | Horizon Laboratory | ● |
| 10. Generate patient lists by specific conditions for quality improvement, reduction of disparities, and outreach. <ul style="list-style-type: none"> • Measure: Generate at least one report. | Medical Records Pharmacy Management | ● |

Meaningful Use Criteria

| Stage 1 Objectives/Measures | Phase 1 Products | Additional Paragon Products Required |
|---|---|--|
| 11. Report hospital quality measures to CMS or the States. <ul style="list-style-type: none"> Measure: Report aggregate numerator and denominator quality data through attestation in 2011 and electronically submit measures by 2012. NEED TO DETERMINE IF ABLE TO CAPTURE CURRENT 35 REQUIRED MEASURES | |  Midas - Paragon |
| 12. Implement 5 clinical decision support rules with the ability to track compliance. <ul style="list-style-type: none"> Measure: Relevant to the clinical quality metrics. | Pharmacy Management Webstation for Physicians |  Phase 2 - CPOE |
| 13. Check insurance eligibility electronically from public and private payers. <ul style="list-style-type: none"> Measure: For at least 80% of all unique patients. | Registration Patient Management <i>and either Real Time Eligibility or Verifier with RelayHealth</i> RevRunner (Release 4.2) |  |





Meaningful Use Criteria

| Stage 1 Objectives/Measures | Phase 1 Products | Additional Paragon Products Required |
|---|--|--|
| 14. Submit claims electronically to public/private payers. • Measure: At least 80% of all claims. | Patient Management | ● |
| 15. Provide patients with an electronic copy of their health information, upon request. • Measure: Provide within 48 hours to at least 80%. | Patient Management and either EC2000 (Release 16.0) or RelayHealth ePREMIS (Release 4.0) | ● |
| 16. Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request. • Measure: Provide to at least 80%. | Clinical Carestation or Order Management Release of Information | ● |

Meaningful Use Criteria

| Stage 1 Objectives/Measures | Phase 1 Products | Additional Paragon Products Required |
|---|--|--|
| <p>17. Capability to electronically exchange key clinical information among providers of care and patient authorized entities.</p> <ul style="list-style-type: none"> • Measure: Performed at least one test of certified EHR technology's capacity. | <p>Clinical CareStation Order Management Pharmacy Management Medical Records Transcriptions and/or interface Horizon Laboratory and/or interface Radiology and/or interface Release of Information</p> | <p>●</p> <p>Phase 2 - Paragon Connect</p> |
| <p>18. Perform medication reconciliation at relevant encounters and each transition of care.</p> <ul style="list-style-type: none"> • Measure: For at least 80%. | | <p>●</p> <p>Phase 2 - CPOE Medication Reconciliation</p> |
| <p>19. Provide summary care record for each transition of care and referral.</p> <ul style="list-style-type: none"> • Measure: For at least 80%. | <p>Clinical CareStation Order Management Pharmacy Management Medical Records Transcriptions and/or interface Horizon Laboratory and/or interface Radiology and/or interface Release of Information</p> | <p>●</p> <p>Phase 2- Paragon Connect</p> |

Meaningful Use Criteria

| Stage 1 Objectives/Measures | Phase 1 Products | Additional Paragon Products Required |
|--|---|---|
| 20. Capability to submit electronic data to immunization registries and actual submission where required and accepted. • Measure: Performed at least one test of certified EHR technology's capacity. | |  Phase 2 - Paragon Connect |
| 21. Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received. • Measure: Performed at least one test of the EHR system's capacity. | |  Phase 2 - Paragon Connect |
| 22. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice. • Measure: Performed at least one test of certified EHR technology's capacity. | |  Phase 2 - Paragon Connect |
| 23. Protect electronic health information created or maintained by the certified EHR through the implementation of appropriate technical capabilities. • Measure: Conduct or review a security risk analysis and implement updates as necessary. | Paragon Application Security, and Windows 2008/SQL Server 2008 |  |

Business Term Sheet

Doctors Medical Center San Pablo Pinole, Inc

Customer Number: 1010453

Opportunity Number: 1-10H9B3

CE: Doug Griffing

May 19, 2010

| | One Time List Price | One Time Net Price | List Annual Recurring Fees (Excluding Maintenance) | Net Annual Recurring Fees (Excluding Maintenance) | Annual Maintenance Fee |
|-----------------------------------|------------------------|-----------------------|---|--|------------------------------|
| Software: | | | | | |
| Software and Software Maintenance | \$1,759,238 | \$42,228 | \$17,613 | \$17,613 | \$316,485 |
| Services: | | | | | |
| Implementation Services | \$1,612,708 | \$1,294,076 | N/A | N/A | N/A |
| Equipment: | | | | | |
| Equipment | \$155,439 | \$133,388 | N/A | N/A | N/A |
| Technology Services | \$14,665 | \$14,665 | N/A | N/A | \$3,900 |
| TOTAL | \$3,542,050 | \$1,484,357 | \$17,613 | \$17,613 | \$320,385 |

| | One-Time Set Up Fees | One-Time Net Set Up Fees | List Monthly Recurring Fees | Net Monthly Recurring Fees |
|---------------------------------|-------------------------|-----------------------------|--------------------------------|-------------------------------|
| Processing Services: | | | | |
| RelayHealth Processing Services | \$22,134.00 | \$22,134.00 | \$13,237.50 | \$13,237.50 |

Facilities

Doctors Medical Center San Pablo Pinole, Inc - 1010453

Terms

Payment Terms

Software: 25% is due on the CS Effective Date and the remaining 75% is due in five equal, consecutive, monthly payments beginning 30 days after the CS Effective Date.

Annual Maintenance: The first Annual Software Maintenance Fee is due on the earlier of Live Date or 12 months from the CS Effective Date.

Implementation & Education Services (Fixed Fee): 100% is due in 12 equal, consecutive, monthly payments beginning upon the CS Effective Date.

Implementation Services (Time and Materials): 100% is due monthly as incurred.

Equipment: Each component piece of the Equipment is 100% due on the delivery date of that component piece.

Technology Services: 100% is due on the CS Effective Date.

Processing Services: Commence upon date Customer submits Transactions (unless an add on order). The fees will be calculated using the greater of the minimum monthly volume or actual transactions. (For Ambulatory charge would be provider fee times the number of providers)

Processing Services Implementation: 100% is due on the CS Effective Date.

Term Software: "The first annual Term Software License Fee is due and payable on the Contract Supplement Effective Date. Subsequent annual License Fees during the Initial Term and any Renewal Term is due on the anniversary of the first annual Software License Fee due date."

Business Terms

Five year initial maintenance term, annual increase will not exceed 5%.

Travel & out-of-pocket expenses reimbursed monthly

Software & Services pricing is valid for 90 days from quote dates

Equipment pricing is valid for 60 days from quote date

Processing Services: Three year term, annual inflation adjustment lower of ECI or 5%

This Business Term Sheet represents our agreement regarding key business terms for the proposed transaction, subject to execution of mutually agreed legal documents. This Business Term is not legally binding for any purpose, but instead will facilitate contract development by McKesson.

Doctors Medical Center San Pablo Pinole, McKesson Provider Technologies

Initials _____

Initials _____

Confidentiality:

The terms and conditions set forth herein of this Pricing Proposal are confidential and proprietary to McKesson. Except as required by applicable law, all confidential information received from McKesson (including pricing) shall be kept strictly confidential by the receiving party and shall not, without prior written consent of McKesson, be disclosed by the receiving party to any third party. All right, title, and interest in and to the confidential information shall remain the property of McKesson.



Employee Health Benefits

Tab 6

**DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM**

TO: DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY

FROM: Richard S. Reid, CFO

DATE: June 23, 2010

SUBJECT: Approval of Keenan & Associates as the Third Party Administration Services for Employee Health Insurance

REQUEST / RECOMMENDATION(S): Approve and authorize the Chief Financial Officer, to execute on behalf of DMC, a 29 month or 2 years 5 months contract with Keenan & Associates for Third Party Administration Services of the employee healthcare insurance coverage. The total contract cost is \$656,536 with administration costs in 2010 of \$114,920.

FISCAL IMPACT: \$ 656,536 for entire contract with \$114,920 in the 2010. These costs are included in the approved 2010 operating budget.

STRATEGIC IMPACT: The plan will provide the same level of benefits to the employees with improved customer service and administrative simplification. DMC selected Keenan & Associates based upon the results of a Request for Proposal process.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION:

Presentation Attachments: Yes X No

Requesting Signature: _____ Date: / /

SIGNATURE(S):

Action of Board on / / Approved as Recommended Other

Vote of Board Members:

 Unanimous (Absent)

Ayes: Noes:

Absent: Abstain:

| |
|---|
| I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN. |
|---|

Contact Person: Richard Reid

Attested _____
Eric Zell, Management Authority Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

THIRD-PARTY ADMINISTRATION SERVICES AGREEMENT

This **Third-Party Administration Services Agreement** ("Agreement") is made and entered into by and between West Contra Costa Healthcare District dba Doctors' Medical Center San Pablo ("Client") and **Keenan & Associates** ("Keenan"), as of August 1, 2010 ("Effective Date"). Client and Keenan are also referred to individually as a "party" and collectively as the "parties."

RECITALS

- A. Client has adopted a self-funded employee welfare benefit plan ("Benefits Plan"), as described in the Client's approved Plan Documents, such as the actual Plan Document, any amendments to it, Summary Plan descriptions or any other Plan changes ("Plan Documents"), which provides certain healthcare and prescription drug benefits for those employees electing to participate in the Benefits Plan ("Covered Employees"), eligible dependents of Covered Employees, and qualified COBRA beneficiaries (each a "Beneficiary") at Client's facilities;
- B. Keenan is a specialty insurance services provider with expertise in the insurance and related service needs of California school districts, municipalities, health care providers and their affiliated entities and, as such, is qualified to provide the Services described in this Agreement; and
- C. Client has requested that Keenan provide Client the Services described in this Agreement and Keenan desires to provide such Services.

The parties agree as follows:

AGREEMENT

1. TERM

The Term of this Agreement is from August 1, 2010 through December 31, 2012 ("Term") and may be renewed for additional one year terms upon mutual agreement of the parties, unless either party gives the other at least sixty (60) days written notice of its intent not to renew, or if the Agreement is terminated earlier as provided under Section 10. Prior to each renewal of this Agreement the billing rates for the upcoming renewal Term stated in Exhibit B – Schedule of Fees shall be renegotiated.

2. KEENAN RESPONSIBILITIES AND SCOPE OF SERVICES

- A. Client elects and Keenan shall provide the Services selected below ("Services") for its Benefits Program. A full description of the available Services is provided in Exhibits A-1 through A-9 attached hereto and incorporated herein.

Exhibit A-1: Claims Administrative Services

Exhibit A-2: Plan Administrative Services

Exhibit A-3: HIPAA Administrative Services

Exhibit A-4: Web Enrollment Access

Exhibit A-5: Over-Age Dependent Notification Service

Exhibit A-6: Third-Party Liability Recovery Service

Exhibit A-7: Vendor Disbursement Service

Exhibit A-8: COBRA Administrative Services

Accept

Decline

| | |
|-------------------------------------|-------------------------------------|
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Exhibit A-9: Medicare Part D Certificates



- B. The relationship of the parties shall be that of independent contractor and each party shall at all times remain responsible for its own operational and personnel expenses. Under no circumstance shall any employee of one party look to the other party for any payment or the provision of any benefit, including without exception, workers' compensation coverage. Except as may be expressly set forth in or contemplated by this Agreement, neither party shall have the right to act on behalf of the other, or to bind the other to any contract or other obligation.
- C. Keenan shall not provide any legal, tax, or accounting service, advice, or opinion, and under no circumstances, are the Services to be construed or interpreted as representing any such advice or opinion. It is Client's responsibility to seek the counsel of its own attorney on all legal issues and to consult with its own tax and accounting experts on all tax, accounting, and financial matters relating to its operations, including without limitation, the establishment, implementation and operation of its Benefits Plan.
- D. In providing its Services Keenan shall comply with all applicable state and federal laws and regulations, and obtain and maintain all necessary licenses, registrations, and/or permits necessary for the performance of its duties under this Agreement.
- E. Keenan reserves the right to engage independent contractors and/or subcontractors to assist it in performing the Services. The use of such individuals shall not relieve either party of any of its duties under this Agreement.
- F. Keenan shall not act as a fiduciary of the Plan as that Term is defined by the Employee Retirement Income Security Act of 1974, et seq. ("ERISA") or any other applicable law or regulation. Keenan's functions are performed pursuant to the express Terms and conditions of the Benefit Plan established by Client.

3. CLIENT'S DUTIES AND RESPONSIBILITIES

- A. Subject to the specific Services set forth herein, Client, as the Plan Administrator for the Plans for purposes of the applicable state or federal law, shall retain all final authority and responsibility and expenses incidental thereto unless specifically assumed by Keenan hereunder, and Keenan is authorized to act on behalf of Client in connection with the Plans only as expressly stated in this Agreement. Client shall retain final authority and responsibility and expenses incidental to the management of the Plans, and is responsible for all other aspects of the Plans, except for the Services to be provided by Keenan under this Agreement.
- B. Client shall notify Keenan in writing of any change in the eligibility requirements for benefits or any other change that may have an effect on the payment of benefits under the Benefits Plan at least sixty (60) calendar days before the desired effective date of the change. Client shall notify Keenan of any such change in writing and the notice shall set for the effective date of any such change. Client shall reimburse Keenan for any expenses incurred by Keenan as a result of any re-programming of Keenan's existing electronic information technology systems that is required in order to implement the change. Keenan will not be responsible for any failure in its performance if any such change is not communicated in the manner described in this Section 3B.
- C. Client shall provide Keenan with timely access to such information and individuals, including its outside advisors and consultants, as may be necessary for Keenan to

perform the Services. Meetings, telephone calls, and other necessary communications shall be scheduled at the mutual convenience of the parties and their representatives. Keenan shall not be responsible for any delay in its performance that results from the failure of Client, or any person acting on behalf of Client, to make available any information or individual in a timely manner.

- D. Client represents and warrants that all information provided to Keenan shall be timely provided, complete, accurate and current, and that Keenan may rely upon such information without further investigation or review. Client understands such information will not be audited by Keenan, and that Keenan shall have no liability to Client or to any third person as a result of Keenan's reliance on any information provided to it by Client, or Client's outside representatives (e.g., Client's accountant's, attorneys, advisors, etc).
- E. Comply with all federal, state, and local reporting and filing requirements for the Benefits Plan.
- F. Pay any and all city, county, state, or federal taxes or assessments charged against the Benefits Plan and the Client.

4. **COMPENSATION**

- A. Keenan shall receive compensation for the Services rendered under this Agreement as provided in the attached Exhibit B. The monthly Service fees charged by Keenan will be based on the number of Covered Employees and qualified COBRA beneficiaries per month. Keenan shall multiply the monthly fees by the number of Covered Employees on the date the billing statement is prepared and such fees shall be payable in advance on a monthly basis and shall be due on the first day of each calendar month for the period of time during which the Agreement is in force.
- B. In the event that the Benefits Plan enrollment declines during the Term of this Agreement to less than 75% of the Benefits Plan enrollment as of the Effective Date, then Keenan may increase the Fees shown on Exhibit B provided that the increase shall not to exceed more than 120% of the current PEPM rate. Keenan shall provide no less than ninety (90) days prior written notice of any such fee increase. If the increase is not acceptable to Client, Client shall have the right to terminate this Agreement on no less than thirty (30) days prior written notice.
- C. Keenan shall bill Client for the cost of any printed materials, including but not limited to, employee booklets, customized forms and/or other communications, which Client has approved in writing in advance of printing. The cost shall be the actual cost of such items plus a 10% handling fee.
- D. Client shall also reimburse Keenan for all any costs incurred for assembling, copying and/or shipping of any materials necessary for Keenan to perform any function required by this Agreement, and for other extraordinary expenses incurred by Keenan which have been approved in writing in advance of printing by Client.
- E. All invoices are due and payable upon receipt. Any balance not paid within thirty (30) days following the date on the invoice shall be deemed late. Interest on any late payment shall accrue as of the date of Keenan's original invoice at the rate of (a) 1½ percent per month, or (b) the maximum interest rate permitted by applicable law, whichever is lower. Keenan shall have the right to suspend its Services if any balance owed by Client is more than sixty (60) days late.

5. **INSURANCE**

Keenan shall procure and maintain during the Term, to the extent available on reasonable Terms, the minimum insurance coverages, and shall provide certificates of insurance to Client upon Client's request.

- A. **Workers' Compensation**: Coverage in conformance with the laws of the State of California and applicable federal laws;
- B. **General Liability**: Coverage (including motor vehicle operation) with a One Million Dollar (\$1,000,000) limit of liability for each occurrence and a Two Million Dollar (\$2,000,000) aggregate limit of liability; and
- C. **Errors and Omissions**: (Professional Liability, if applicable): Coverage with a One Million Dollar (\$1,000,000) limit of liability for each occurrence and a Two Million Dollar (\$2,000,000) aggregate limit of liability.

6. **INDEMNIFICATION**

If either party breaches this Agreement, then the breaching party shall defend, indemnify and hold harmless the non-breaching party, its officers, agents and employees against all claims, losses, demands, actions, liabilities, and costs (including, without limitation, reasonable attorneys' fees and expenses) arising from such breach. In addition, if Keenan (i) becomes the subject of a subpoena or is otherwise compelled to testify or (ii) becomes the subject of a claim, demand, action or liability brought or asserted by one of Client's employees, Plan beneficiaries, or Plan vendors ("Third-Party Demand") relating to the Services and such Third-Party Demand is not a direct result of Keenan's gross negligence or willful misconduct, then Client shall defend, indemnify and hold Keenan harmless from all losses, payments, and expenses incurred by Keenan in resolving such Third-Party Demand. Client shall further indemnify and hold Keenan harmless from any liability incurred by Keenan as a result of Keenan's compliance with any direction, policy, guideline or document of Client.

7. **FINES AND PENALTIES**

Keenan shall pay any fines and/or penalties levied by regulatory authorities arising from Keenan's fulfillment of its obligations under this Agreement that are Keenan's fault and Client shall pay all other fines and/or penalties relating to the Program or otherwise.

8. **LIMITATION OF LIABILITY**

Except as noted in Section 7 above, in no event shall Keenan be liable for any punitive damages, lost profits or revenues, fines, penalties, taxes or any indirect, incidental, special or consequential damages incurred by Client, its officers, employees, agents, contractors or consultants whether or not foreseeable and whether or not based in contract or tort claims or otherwise, arising out of or in connection with this Agreement even if advised of the possibility of such damage. Keenan's liability under this Agreement shall be limited to, and shall not exceed, the amount of its available insurance coverage, but not exceeding the limits of coverage outlined in Section 5.

9. **DISPUTE RESOLUTION**

- A. Disputes arising out of or relating to this Agreement, other agreements between the parties, or any other relationship involving Client and Keenan (whether occurring prior to, as part of, or after the signing of this Agreement) shall first be resolved by good faith negotiations between representative of the parties with decision-making authority. If

either party determines that the dispute cannot be resolved through informal negotiation then the dispute shall be submitted to non-binding mediation. The site of the mediation and the selection of a mediator shall be determined by mutual agreement of the parties. If the dispute is not resolved through mediation within sixty (60) days following the first notification of a request to mediate, then either party shall have the right to require the matter to be resolved by final and binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association, or such other arbitration procedures as may be agreed to in writing by the Parties. Negotiation, mediation, and arbitration shall be the exclusive means of dispute resolution between Client and Keenan and their respective members, agents, employees and officers.

- B. Arbitration shall be before a single arbitrator in the County of Contra Costa, California. The Arbitrator shall apply the Federal Arbitration Act and California substantive law, and shall accompany the award with a reasoned opinion. The arbitrator shall have no authority to award punitive or other damages not measured by the prevailing party's actual damages. The prevailing party shall be entitled to an award of reasonable attorneys' fees. A judgment of any court having jurisdiction may be entered upon the award.
- C. Either party may apply to the arbitrator seeking injunctive relief until the arbitration award is rendered or the controversy is otherwise resolved. Either party also may, without waiving any remedy under this Agreement, seek from any court having jurisdiction any interim or provisional relief that is necessary to protect the rights or property of that party, pending the establishment of the arbitral tribunal (or pending the arbitral tribunal's determination of the merits of the controversy).

10. **TERMINATION**

- A. Either party may terminate this Agreement upon the occurrence of any of the following events:
 - 1. Client may terminate this Agreement at any time without penalty upon sixty (60) days' written notice to Keenan;
 - 2. The failure of Client to fund the claims payment account which failure remains uncorrected five (5) or more days following notice by Keenan that funds are necessary;
 - 3. A breach of this Agreement by either party that is not cured within thirty (30) days following receipt of written notice of the breach from the non-breaching party;
 - 4. In the event of a fee increase as provided in section 4B;
 - 5. The dissolution or insolvency of either party;
 - 6. The filing of a bankruptcy petition by or against either party (if the petition is not dismissed within sixty (60) days in the case of an involuntary bankruptcy petition); or
 - 7. If the application of any law, rule, regulation, or court or administrative decision prohibits the continuation of this Agreement or would cause a penalty to either party if the Agreement is continued, and if the Agreement cannot be amended to conform to such law, rule, regulation, or court or administrative decision in a manner that would preserve the original intent of the parties with respect to their rights and duties under this Agreement.

B. Upon termination of this Agreement:

1. Keenan shall be entitled to payment only for the pro-rata portion of the Term during which Services were provided. Any monies paid to Keenan in excess of this pro-rata amount shall be refunded to the Client.
2. Keenan will promptly, but in no event later than five (5) business days after the effective date of termination, provide Client with a list of all claims under the Plan that have not been processed and have dates of service prior to the effective date of termination (the "Run-Off Claims").
3. If Client so elects, which election shall be effective if Client gives written notice thereof to Keenan no later than two (2) business days following the effective date of termination, Keenan will continue to process the Run-Off Claims in accordance with the Terms of this Agreement.
4. Keenan's compensation for handling the Run-Off Claims shall be as follows:
 - i. For the first four (4) months following termination of this Agreement, Client shall pay Keenan an amount equal to the monthly fee that was in effect during the last month of the Agreement; and
 - ii. Beginning with the first day of the fifth month following termination of this Agreement, Client shall pay Keenan a flat fee in the amount of \$15.00 per claim remaining open thereafter.
 - iii. The Run-Off administration fee is payable monthly within thirty (30) days after receipt of Keenan's invoice showing the total number of Run-Off Claims remaining open during the period covered by the invoice.
 - iv. Keenan's responsibility for the management of Run-Off claims shall end as soon as all Run-Off claims are closed or twelve months from the termination date of this Agreement, whichever comes first.
5. Client may terminate the Run-Off Claims processing Services of Keenan hereunder at any time upon no less than thirty (30) days written notice.
6. Keenan shall within thirty (30) days following the termination of this Agreement return to Client all records relating to the Claims processed by Keenan, except that:
 - i. Keenan shall have the right to retain copies of any and all records that it deems necessary in order to document the provision of its Services hereunder; and
 - ii. Keenan shall retain the records pertaining to any Run-Off claims managed by Keenan, but shall return all such records within thirty (30) days after the last Run-Off Claim is closed or when Keenan stops managing the Run-Off Claims, whichever comes first.

11. **SOLICITATION OF EMPLOYEES**

Throughout the Term of this Agreement and for one (1) year following its termination date, Client shall not solicit directly or indirectly (whether as an employee, consultant or otherwise, or for itself or a third-party) any of Keenan's employees, contractors or consultants who performed work for Client under this Agreement without Keenan's prior written approval.

12. **PROPRIETARY INTERESTS**

Keenan shall retain the copyright and the sole right of ownership to any report, tool, schedule, exhibit, assessment, analysis, or other deliverable, that is created or developed by Keenan in performing its Services and provided to Client in any media whatsoever. Client shall, however, remain the owner of any Client data or information that was provided to Keenan for the performance of the Services. Any deliverable created by Keenan for Client shall be used for Client's internal purposes and shall not be used without the written consent of Keenan, for Client's commercial gain, nor shall it be distributed to or shared by Client with any third person, except as may be necessary to accomplish the intent and purpose of this Agreement.

13. **MARKETING**

Keenan may use Client's name in its representative Client list and for any other reasonable marketing activities. Keenan shall obtain Client's written consent before using Client's name for any other purpose.

14. **OTHER RELATIONSHIPS**

- A. Keenan or its affiliates may provide Client or others with other Services or insurance coverage not provided in this Agreement and may receive compensation related to such other Services which may include, without limitation, loss control Services, joint powers administration, insurance brokerage Services, securing reinsurance, claims administration, investigative Services, financial processing and other related Services.
- B. Keenan and/or its affiliate may provide Services for other entities that also participate in and/or contract with the Program (e.g., insurers and reinsurers providing coverage under the Program) and to the extent that such Services are provided, Keenan will be separately compensated for those Services.
- C. The Services provided to Client are non-exclusive and Keenan reserves the right to provide the same or similar Services to other Clients who may be in the same industry, business, or Service as Client.

15. **RECORDS**

- A. Client shall be the owner of records relating to claims for benefits under the Plan, any duly authorized representative of Client shall have the right to examine or audit records during Keenan's regular business hours, upon five (5) days written notice to Keenan. Client shall have the right to request, at its own expense, copies of any information and/or records maintained by Keenan relating to the Claims managed pursuant to this Agreement.
- B. Keenan shall not dispose of any records delivered by Client, without Client's prior written approval.
- C. Keenan shall take reasonable and prudent steps to secure and safeguard Client's records, and any copies, while such records are in the possession of Keenan.
- D. All information and records, which are compiled by, obtained by or furnished to Keenan under this Agreement, are acknowledged and understood to be Confidential Information. During and after the Term of this Agreement, Keenan agrees that it will not, directly or indirectly, divulge in any manner, or use or permit others to use any of

this information or records, except to the limited extent necessary to perform Keenan Services on behalf of Client under this Agreement.

16. CONFIDENTIALITY

- A. As a result of their relationship under this Agreement each party may gain access to Confidential Information concerning the other. For purposes of this Agreement, the Term "Confidential Information" includes, without limitation; i) any information described in Section 15D above; ii) any information or data about a party's business operations, Clients, employees, marketing plans, method of operation, trade secrets, and financial performance; iii) information about any individual participating in the Benefits Program, such as name, address, social security number, compensation, and medical history; and iv) any other information about a party that is not available to the general public. Neither party shall, without the written consent of the other release, disclose, or disseminate the other party's Confidential Information except as is necessary for the performance of the Services.
- B. In the event that either party becomes the subject of a subpoena or court order compelling the disclosure of the other party's Confidential Information, that party shall immediately notify the other so that the party whose Confidential Information is being sought can take such action as may be necessary to prevent or limit the release of its Confidential Information.
- C. Neither party shall be deemed to be in breach of this Section 16 if it has notified the other before it releases the Confidential Information pursuant to a subpoena or court order, and the party whose Confidential Information was requested fails to provide, before the deadline for disclosure, a copy of court order quashing the subpoena or otherwise limiting the original demand for the Confidential Information.

17. INSPECTION OF RECORDS (Applies only to Clients receiving Medicare funding)

- A. Until the expiration of four (4) years after the furnishing of the services provided under this contract, Keenan shall cooperate fully with Client by maintaining and making available all necessary records, or by executing any agreements, in order to assure that Client will be able to meet all requirements for participation and payment associated with public or private third party payment programs including, but not limited to, the Federal Medicare program. Consistent with the foregoing, Keenan agrees to comply with § 1861(v)(1)(I) of the Social Security Act, as amended, and any regulations promulgated pursuant thereto, under which Keenan agrees to maintain its books, documents and records that are necessary to certify the nature and extent of such services and payments under this Agreement and to furnish such books, documents and records, upon written request to the Secretary of Health and Human Services or to the Comptroller General, or any of their duly authorized representatives. If Keenan is requested to disclose books, documents or records pursuant to this Section for purpose of an audit, Keenan shall notify Client of the nature and scope of such request and Keenan shall make available, upon written request of Client, all such books, documents or records, during regular business hours of Contractor.
- B. If Keenan carries out its Services through a subcontract worth \$10,000.00 or more over a twelve (12) month period with a related organization, the subcontract will also contain

an access clause to permit access by the Secretary of Health and Human Services or to the Comptroller General, or any of their duly authorized representatives to the related organization's books and records.

18. **GENERAL**

- A. The Agreement, its recitals and all exhibits and amendments attached to the Agreement (incorporated into this Agreement by this reference) contain the entire understanding of the parties related to the subject matter covered by this Agreement and supersede all prior and collateral statements, presentations, communications, reports, agreements or understandings, if any, related to such matter(s).
- B. The obligations of this Agreement (other than Keenan's obligation to perform Services and Client's obligation to pay for such Services, if any, except as provided under Section 10B) shall survive the expiration or termination of this Agreement.
- C. This Agreement is made for the benefit of the parties and is not intended to confer any third-party benefit or right. The enforcement of any remedy for a breach of this Agreement may only be pursued by the parties to this Agreement.
- D. No modification or amendment to this Agreement shall be binding unless in writing and signed by authorized representatives from both parties. Any waiver or delay by a party in enforcing this Agreement shall not deprive that party of the right to take appropriate action at a later time or due to another breach. This Agreement shall be interpreted as if written jointly by the parties.
- E. Any provision determined by a court of competent jurisdiction to be partially or wholly invalid or unenforceable shall be severed from this Agreement and replaced by a valid and enforceable provision that most closely expresses the intention of the invalid or unenforceable provision. The severance of any such provision shall not affect the validity of the remaining provisions of this Agreement.
- F. Neither party shall be liable or deemed to be in default for any delay or failure in performance under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, power outages, failure of computer systems, machinery or supplies, vandalism, strikes, or other work interruptions, or any similar or other cause beyond the reasonable control of either party. Both parties shall make good faith efforts to perform under this Agreement in the event of any such circumstances, and full performance shall resume once the cause of the delay has abated.
- G. All notices hereunder shall be in writing and shall be sent to the signatories at the addresses as set forth following their signatures, or to such other individual or address as a party may later direct. Notices shall be sent via personal delivery, courier service, United States mail (postage pre-paid, return receipt requested), express mail courier, electronic mail, or fax. Notice shall be effective when delivered, or if refused, when delivery is attempted. Notices delivered during non-working hours shall be deemed to be given as of the next business day.

If the notice relates to a legal matter or dispute, a copy shall be sent to:

Keenan & Associates
2355 Crenshaw Blvd., Ste. 200
Torrance, CA 90501
Attn: Legal Department
Fax: (310) 533-0573

- H. Each party hereby represents and warrants that it is not and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid. Each party hereby agrees to immediately notify the other party of any threatened, proposed, or actual exclusion from any federally funded health care program, including Medicare and Medicaid. In the event that a party is excluded from participation in any federally funded health care program during the Term of this Agreement, or if at any time after the effective date of this Agreement it is determined that a party is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate.
- I. This Agreement may be executed in counterparts and by fax signatures and each shall be deemed to be an original.

Each person signing this Agreement on behalf of a party represents and warrants that he or she has the necessary authority to bind such party and that this Agreement is binding on and enforceable against such party.

| <u>West Contra Costa Healthcare District dba Doctors' Medical Center San Pablo</u> | | <u>Keenan & Associates</u> | |
|---|----------------------------|---------------------------------------|---------------------------------------|
| Signature: | | Signature: | |
| By: | Joseph A. Stewart | By: | Walter T. Pregizer |
| Title: | CEO | Title: | Vice-President, Benefit Claims |
| Address: | 2000 Vale Road | Address: | 2355 Crenshaw Blvd., Ste. 200 |
| | San Pablo, CA 94806 | | Torrance, CA 90501 |
| Telephone: | (510) 970-5000 | Telephone: | (310) 212-0363 |
| Fax: | (510) 970-5741 | Fax: | (310) 212-3381 |
| Attention: | Amy Mendoza | Attention: | Walter T. Pregizer |
| Date: | | Date: | |

EXHIBIT A-1
CLAIMS ADMINISTRATIVE SERVICES

I. DEFINITIONS

- A. Actual Charge – the amount billed by a health care provider for a particular Service.
- B. Adjusted Claim – a Claim that has been reprocessed following an appeal or request for reconsideration.
- C. Appeal – the process by which Provider or Beneficiary who has received notice of a denial may request and receive a reconsideration of the claim. The manner of appeal shall be as described in the Plan or applicable agreement between the Provider and the Network.
- D. Beneficiary – an individual who is entitled to receive healthcare benefits through the Client's Plan.
- E. Claim – a request for payment of benefits under Client's Plan.
- F. Claims Account – a checking account upon which checks may be drawn for the payment of Claims.
- G. Covered Claim – a Claim for Covered Services provided to a Beneficiary.
- H. Covered Services – Healthcare Services that are eligible for reimbursement under the Terms of Client's Plan.
- I. Denial – A determination that all or part of a Claim is not a Covered Claim and will not be paid.
- J. Explanation of Benefits (EOB) - a statement explaining the action taken on a Claim.
- K. Repriced Claim - a Claim that has been priced to reflect the PPO rate, or, in the case of non-Network Providers, the UCR.
- L. Contract Rate – the fee agreed upon by a PPO Network Provider and its Network.
- M. Network – an entity that sponsors a PPO and that has an agreement with one or more Providers who have agreed to provide healthcare services at Negotiated Rates.
- N. Plan – the Client's welfare Benefit Plan.
- O. Usual and Customary Rate (UCR) - the allowable charge for a Healthcare Service as defined in the Plan.
- P. Preferred Provider Organization (PPO) – a group of Providers who have signed an agreement with a Network to provide Healthcare Services at contracted rates.
- Q. Provider – a Healthcare practitioner or facility as defined in the Plan.

II. GENERAL

- A. Keenan's responsibility is limited to processing claims with dates of service after the effective date of this Agreement. Keenan will not be responsible for any medical or vision claim with a date of service prior to the effective date of this Agreement, or for any claim submitted to Client or any other claims administrator before the effective date of this agreement unless Keenan has expressly agreed in writing to take over the administration of such claims.

- B. Keenan shall review and adjudicate Claims, including examination of Claims and determination of payment levels in accordance with the Plan Documents' claims procedure, including data entry of claims by claims department, maintenance of claims experience files, use of medical consultants, review of utilization and reasonable and customary charges and coordination of benefits, and processing of claim appeals in accordance with the Plan Documents and in a manner that complies with the requirements of ERISA and/or the Department of Managed Health Care, as applicable;
- C. Keenan will use its discretion in processing claims, provided, however, that Keenan's actions shall at all times be subject to the Plan Documents, claims handling guidelines, and such other protocols and/or directives as Client may establish. Keenan shall have no obligation to follow any document, guideline, protocol or directive issued by Client until Keenan has received a written copy of such guideline, protocol or directive. Keenan shall have no responsibility or liability to Client or any third person for any actions taken, including without limitation, the payment or denial of any claim unless it shall be determined that Keenan acted in willful disregard of Client's rules, protocols and directives, in violation of any applicable law or regulation, or in a manner that was grossly negligent. Keenan shall not be liable to Client for following any directive, guideline, protocol, procedure, or policy, whether written or oral, of or from the Client.

III. ELIGIBILITY, COVERAGE AND CLAIM SUBMISSIONS

A. Client Duties:

1. Client shall identify or certify individuals eligible to receive benefits under the Benefits Plan and shall provide Keenan with the names of all Beneficiaries. Client will provide Keenan with eligibility lists in the manner and frequency established by mutual Agreement of the parties.
2. Client shall provide Keenan with a copy of the applicable Plan and shall notify Keenan in writing of any Plan changes at least thirty (30) days before the effective date of such change. Keenan shall not be responsible for its failure to comply with any Plan change that has not been communicated to it as provided in this paragraph.
3. Client shall also provide dates of eligibility and other information as required to evaluate claims, including but not limited to, eligibility for qualified COBRA beneficiaries (regardless of whether or not COBRA continuation Services, as provided by Keenan, are selected by the Client for administration).
4. Timely respond to Keenan's requests for verification of eligibility and/or covered Services and such other information as may be necessary from time to time for Keenan to fulfill its duties under this Agreement.
5. Review and evaluate any claim appeals, make the final determination with respect to eligibility for benefits, and to notify Keenan, in writing, of its final decision. Client shall provide notification to Keenan no later than thirty (30) days after it has received a request for a determination.
6. Notify Keenan, in writing, of its disagreement with any claim decision by Keenan. Keenan will implement the Client's interpretation of the Benefits Plan's provisions on all subsequent claims as soon as reasonably possible but no later than forty-five (45) business/working days after the receipt of the written notice.

7. Not knowingly require or instruct Keenan to perform administrative functions for any benefit or program that violates any state or federal regulation and to pay any fine or penalties that may be imposed by any regulatory body for such violations.
8. Ensure that claims are submitted on forms approved by Keenan.
9. Client shall comply with the Terms of the any applicable agreement executed between Client and a Network with respect to the processing of any PPO claims.

B. Keenan Duties:

1. Keenan shall comply with the Terms of the applicable Claims Handling Service Agreement in the processing of all PPO claims.
2. Prepare, order and/or issue, as agreed to by the parties, benefit identification cards, if applicable, to the Beneficiaries.
3. Upon receipt of a Claim Keenan shall verify that the Claim is a Covered Claim.
4. If the Covered Claim is from a PPO Provider the Network shall reprice the Claim and advise Keenan of the amount of the repriced Claim.
5. If the Covered Claim is not from a PPO Provider, Keenan shall determine the UCR.
6. Under no circumstance will Keenan be liable to Client for any financial loss sustained by Client resulting from or arising out of a repricing decision made by the Network, irrespective of whether the repricing is the result of an initial claims evaluation, or a review or appeal of a previously repriced Claim.
7. Keenan shall prepare and submit to the Beneficiary and Provider an EOB for each Claim submitted, irrespective of whether the Claim is approved or denied. The EOB shall detail what billed Services are or are not Covered Services, the Actual Charge and Negotiated Rate for the Covered Service, the amount of the available benefit, and the amount, if any, including any applicable deductible and co-payment that is the responsibility of the Beneficiary. The EOB shall also contain information about appeal rights for denied Claims.
8. Provider shall have the right to appeal any denial in accordance with the Terms of such Provider's agreement with its Network. Keenan has no authority over, nor shall it be liable for, the timing of any appeal or any payment decision rendered pursuant to an appeal. Client understands that it is possible that an appeal decision may be rendered considerably after the date of the denial. This could result in the payment of a previously denied Claim in a new stop-loss year. In such event the Claim payment may be subject to an additional stop-loss deductible or exclusions depending upon the Terms of Client's stop-loss policy.
9. Keenan shall pursue reasonable cost containment strategies which may include, without limitation, the use of one or more third-party vendors to review quality and/or appropriateness of Services, negotiate pricing on large dollar claims, and provide fraud detection Services. The cost of such Services may vary and is generally based on a percentage of the Client's savings. The fee charged by the vendor will include Keenan's administrative fee for this service. Charges will be billed to Client and paid for from the Claims Account.

IV. CLAIMS PAYMENT

A. Client Duties:

1. The Claims Account shall be established by: ☒ Keenan ☐ Client (check one)
2. Keenan shall be authorized to write checks from the Claims Account for the payment of Claims.
3. Client shall fund the bank account to ensure that there are sufficient funds available to pay all Claims in accordance with procedures to be established in writing and agreed to by Client and Keenan.
4. Client shall complete a separate Funding/Banking Arrangements Sheet during the implementation process.
5. Unless otherwise agreed to in writing, Client shall reconcile the Claims Account.

B. Keenan's Duties:

1. Keenan shall process, issue and distribute payments for all Covered Claims;
2. Keenan shall pay or deny each Claim in accordance with the requirements of ERISA, or, if the Plan is not subject to ERISA, in accordance with applicable state law. Keenan shall not, however, be liable to Client for any failure to meet the statutory payment requirements if the failure results from the delay of Client, Network, or any other individual or entity, as applicable, to provide Keenan with the information necessary to timely process the Claim, or from the failure of the Client to fund the Claims Account;
3. Keenan will report to Client not less than weekly with respect to all payments that have been made from the Claims Account since the date of Keenan's last report;
4. Under no circumstances shall Keenan advance any money for the payment of any Covered Claim, or to independently provide any benefit described in the Plan Documents or the Summary Plan Description or amendments to either;
5. Upon request, Keenan shall provide Client with vouchers for internal control and reconciliation purposes whenever funds are transferred from the Claims Account other than in the form of a written check;
6. Keenan shall timely respond to authorized inquiries from Providers and Beneficiaries regarding their Claims.

V. RECORDKEEPING AND REPORTING

Keenan shall:

1. Establish and maintain appropriate records to monitor a Beneficiary's deductible, coordination of benefits, co-payments, and maximum benefits payable under the Plan;
2. Report to Client's stop-loss carrier, if any, in accordance with the requirements of the applicable stop-loss policy;
3. All reports to stop-loss carrier shall be in the format reasonably requested by such carrier;
4. Utilize professional consultants in connection with the review of a Claim only after obtaining prior written authorization from Client. Expenses associated with the use of any such consultants shall be paid by the Client;

5. Keenan shall issue to providers of service and the Internal Revenue Service ("IRS") Form 1099 reports, which document claim payments to providers;
6. Upon discovery of a payment discrepancy, take appropriate measures to correct any problems that caused the payment discrepancy and recover monies paid or spent on behalf of Client or Beneficiaries;
7. At Client's request Keenan shall provide standard forms for the submission of Claims;
8. Keenan shall have no responsibility for pursuing third-party liability claims on Client's behalf unless Exhibit A-6 is selected in the previous section. If Exhibit A-6 is not selected, Keenan's responsibility regarding third-party liability claims shall be limited to:
 - a. Notifying the Client that a third-party's liability has been determined; and
 - b. Notifying the affected Beneficiary of Client's right to recovery of damages that the Beneficiary may receive from any third-party.
9. Except as may be otherwise agreed to in writing by the parties, Keenan shall provide Client with the following report on a weekly basis:
 - a. Check Register;
 - b. Remittance Advice (Consolidated Voucher Register).
10. Except as may be otherwise agreed to in writing by the parties, Keenan shall provide Client with the following reports on a monthly basis:
 - a. Claims Lag Report;
 - b. Check Register;
 - c. Paid Claims in Excess of \$10,000;
 - d. Paid Claims in excess of \$25,000 year to date;
 - e. Monthly Paid Claims Summary by Employee/Dependent;
 - f. Specific Stop-Loss Report;
 - g. Aggregate Stop-Loss Report, if applicable.
11. Customized reports, not specified above, shall be available, at Client request, for an additional charge.

EXHIBIT A-3
HIPAA ADMINISTRATIVE SERVICES

1. KEENAN SERVICES

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Keenan agrees to:

- A. Send a Certificate of Creditable Coverage (Certificate of Group Health Plan Coverage) per HIPAA requirements, using the recommended legislative form, to any participants enrolled in the self-funded Medical Plan when required;
- B. Issue a replacement/duplicate Certificate of Creditable Coverage when requested by a participant or beneficiary at Client's expense;
- C. Program Keenan's computer system to generate the HIPAA Notification Letter and Certificate of Creditable Coverage or to accommodate changes associated with the administration of HIPAA Services.

EXHIBIT A-4
WEB ENROLLMENT ACCESS

1. KEENAN SERVICES

Keenan agrees to:

- A. Provide Client set-up for secured access through the Keenan website;
- B. Provide at no charge one training day to Client's employees to access medical benefit eligibility files administered by Keenan and maintain the software system used to access the medical eligibility files. Additional training will be available and may be subject to extra fee.

2. CLIENT'S DUTIES AND OBLIGATIONS

Client agrees to:

- A. Protect the confidentiality of all proprietary information of Keenan;
- B. Furnish employees and equipment necessary to operate the on-line eligibility interface with Keenan;
- C. Instruct employees to follow the suggested guidelines issued by Keenan to maintain eligibility records.

3. RESPONSIBILITY FOR DATA IN COMPUTER SYSTEM

The Parties agree that Client is solely responsible for maintaining and entering eligibility data and thus any damages or liability arising from erroneous information in the system shall be the responsibility of Client. Client further agrees to assume complete responsibility for maintaining the eligibility data and is responsible for the accuracy of the data contained therein.

EXHIBIT A-5
OVER-AGE DEPENDENT NOTIFICATION SERVICE

1. **KEENAN SERVICES**

- A. Keenan, after being notified by Client that a dependent is approaching the limiting age, between 19 to 25 years of age, agrees to:
1. Prepare and send a Request for Student Status Verification letter that includes notification that coverage for the applicable dependent will end if documentation is not provided which would allow the dependent's eligibility for coverage to continue;
 2. Include a dependent information questionnaire with the Request for Student Status Verification letter to be completed by the employee in order to document continued eligibility for coverage. The dependent information questionnaire is to be returned by the employee to Keenan;
 3. The Student Status Verification letter will be sent no later than the month of the dependent's 19th birthday and then annually thereafter.
- B. Client acknowledges and agrees that Keenan's duties and obligations under this Addendum do not include the following:
1. Refunding premiums for retroactive termination of dependent coverage;
 2. Determining validity of the information provided by the Beneficiary;
 3. Following up with the Beneficiary for receipt of the information or response;
 4. Notifying Client's vendors/carriers of any termination or changes to eligibility records.

2. **CLIENT'S DUTIES AND OBLIGATIONS**

Client agrees to:

1. Adjust and update Client's eligibility records and system upon receipt of communication from Keenan informing Client of change in Beneficiary's status;
2. Compensate Keenan for providing the Services described in this Exhibit and for any additional Services, which may be required, but are not identified in this Exhibit;
3. Notify Keenan and any insurance carrier or administrative Service provider of a change in a Beneficiary's eligibility.

3. **KEENAN DISCLAIMER AND NOTICE TO CLIENT**

Keenan shall not be responsible for:

1. The consequences of any action taken, or the failure to act, by Client in connection with the administration of the Over-Age Dependent Notification Service, unless such action or omission is the result of Keenan failing to provide the Services specified in this Exhibit;
2. A Student Status Verification letter that is not received by the employee;
3. Inaccurate computer entries regarding eligibility data or records made by Client or a third-party;
4. Any actions taken by vendors/carriers as a result of any termination, lapses, or cancellations of coverage.

EXHIBIT A-6
THIRD-PARTY LIABILITY RECOVERY SERVICE

A. KEENAN SERVICES

Keenan shall utilize a third-party to identify any claims subject to third liability recovery rights when the amount of benefits paid exceeds \$500.00.

B. ALLOCATION OF RECOVERY

Amounts recovered under this Exhibit will be allocated in the following order:

1. Cost of recovery and administrative fees, including attorney's fees;
2. Reimbursement to stop-loss carriers, if any;
3. Reimbursement to the Benefits Plan.

C. DISCRETIONARY AUTHORITY RETAINED BY CLIENT

The Parties agree that Client retains the sole discretion regarding pursuing, litigating, and/or resolving claims for recovery. This Exhibit A-6 does not transfer to Keenan any discretionary authority regarding the recovery of benefits paid by the Benefits Plan for an injury or illness proximately caused by a third-party.

EXHIBIT A-7
VENDOR DISBURSEMENT SERVICES

1. KEENAN SERVICES

Keenan agrees to:

- A. Establish a "consolidated billing" arrangement with agreed upon vendors whereby the invoices from all such vendors will be consolidated on a single invoice ("Vendor Disbursement Bill") that is delivered to Client by Keenan on a mutually agreed upon date each month. Participating vendors will be expected to forward their monthly invoices to Keenan no less than 30 days before payment is expected. Vendor invoices not received by the 10th day of each month will not be included in the Vendor Disbursement Bill until the next consecutive month.
- B. Ensure payments are made to the vendors within 30 days after Client has remitted the appropriate funds for the payment of the charges listed on the Vendor Disbursement Bill;
- C. Transfer the Service fees, premiums, claims and/or eligibility information from the vendor's invoice to the Client's Vendor Disbursement Bill;
- D. Subdivide billing information into the following categories, if applicable:
 - i. Active/COBRA;
 - ii. Single/2-Party/Family;
 - iii. Departments, locations, or divisions;
 - iv. Miscellaneous subcategories;
 - v. Itemize and total vendor billing information and produce a grand total amount for remittance by Client;
 - vi. Forward the Vendor Disbursement Bill to Client on or after the 10th day of each month; and
 - vii. Prepare checks for the amount of each vendor's invoice and mailing to the vendor 10 working days following receipt of Client's remittance of funds.
- E. Keenan shall disburse payment to vendors in accordance with Client's specific written instruction, if any.
- F. Keenan shall not be responsible for finance or late charges, insurance policy lapses or cancellations, refusals of credit or refund requests imposed by vendors if:
 - i. Vendor invoices are not received by the 10th day of each month;
 - ii. Client's remittance is not received by the 25th day of the month following receipt of the Vendor Disbursement billing;
 - iii. Incorrect payments are due to eligibility errors; or
 - iv. Keenan has followed the Client's written payment instructions.

2. **CLIENT'S DUTIES AND OBLIGATIONS**

- A. Provide to Keenan a list of vendors who will participate in the monthly Vendor Disbursement Program ("Program"):
 - i. Participating vendors must be issuing a monthly invoice to the Client for Service fees or premiums, which are based on claim dollars, monthly eligibility, or payroll deductions/records for group-related products, or vendors must be providing Services, or coverage to the Client without direct invoice;
 - ii. The Client must be providing monthly "up to date" (current within three (3) working days) eligibility to the applicable vendors via manual or electronic transmission;
- B. Establish and maintain a monthly eligibility list or the eligibility data is retained in Keenan's computer system;
- C. Deposit a remittance into a Keenan checking account no later than the 15th day of each month in the amount of at least the grand total of the Vendor Disbursement Bill to vendors; and
- D. To assume the responsibility for instructing its employees on the suggested guidelines issued by Keenan to maintain eligibility records.

3. **COMPENSATION TO KEENAN**

Client shall pay to Keenan a monthly fee per Vendor Disbursement Bill as stated in Exhibit B. The monthly fee is applicable for a maximum of 2 vendors, including Keenan's administrative fee. If more than 2 vendors are to participate, the monthly fee will be increased by \$150 per vendor. A separate setup fee of not less \$300 will be applicable for additional vendors or series of vendors (if more than one vendor is added to the Vendor Disbursement Bill at one time), to which the rules from the Compensation Section of this Agreement shall apply.

Keenan's invoice for its fees will not be included on the Vendor Disbursement Bill. Rather, Client will receive a separate invoice for Keenan's Services and shall render payment directly to Keenan for such Services. Keenan shall not use any portion of the funds remitted by Client for the payment of a Vendor Disbursement Bill.

4. **DISCLAIMER AND NOTICE TO CLIENT**

Client acknowledges and agrees that any disputes that arise from misinformation in the system shall solely be the responsibility of the Client.

5. **INADEQUATE FUNDING**

Keenan shall have the right to discontinue its consolidated billing Services if Client fails to provide adequate funds to cover all charges identified on any Vendor Disbursement Bill and such failure continues for a period of thirty (30) days or more after Keenan has given notice to the Client of the shortfall.

EXHIBIT A-8
COBRA ADMINISTRATIVE SERVICES

1. **KEENAN SERVICES**

Keenan agrees to:

- A. After being notified by Client of Qualified Beneficiary's COBRA Qualifying Event (as those Terms are defined under COBRA);
- B. Prepare a COBRA Election Notice in accordance with Department of Labor guidelines;
- C. Mail the notice via U.S. mail to the last known address of the Qualified Beneficiary(ies), as provided by Client;
- D. Upon receipt of the Qualified Beneficiary's completed COBRA election form, send payment coupons to the COBRA participant or beneficiary;
- E. Send enrolled COBRA participants the following information as applicable, utilizing Keenan forms prepared in accordance with Department of Labor guidelines:
 - i. Notice of Change in COBRA Premium with new payment coupons;
 - ii. Upon notification by Client of the occurrence of an event causing loss of eligibility for COBRA before the maximum coverage period, send Notice of Termination of COBRA Continuation Coverage, which will include the reason for the termination of coverage;
 - iii. When the COBRA coverage of an enrolled participant is expiring, send Expiration of Period of Eligibility for COBRA Coverage letter;
 - iv. Send to enrolled participants, Notice of Premiums Short by Insignificant Amount and subsequent Notice of Termination if deficiency not received within a reasonable time.
- F. Maintain file copies of all Election Notices mailed to Qualified Beneficiaries and Client;
- G. Send Unavailability of COBRA Coverage Notices, as applicable;
- H. Send all communications required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, without limitation, Certificates of Creditable Coverage, notices relating to preexisting conditions, special enrollment rights and privacy and security;
- I. Unless otherwise agreed by the parties, Keenan shall collect COBRA premium payments from enrolled participants, verify that the correct amount was submitted, and forward the premiums to the Client.

2. **CLIENT'S DUTIES AND OBLIGATIONS**

Client agrees to:

- A. Provide General Notice of COBRA Continuation Coverage Rights to all employees and their spouses/ dependents upon commencement of their participation in the Plan;
- B. Provide all COBRA participants with communication materials distributed to active Plan Participants;
- C. Determine if a Qualifying Event has occurred and if the participant or Beneficiary of the Plan is eligible to receive COBRA, and promptly notify Keenan of Client's determination;

- D. Provide Keenan with the names and last known addresses of Qualified Beneficiaries to whom election notices must be mailed;
- E. Comply with any applicable COBRA notice provisions;
- F. Notify Keenan in writing by the next business day whenever Client receives any communication from a Qualified Beneficiary or becomes aware that the status of a Qualified Beneficiary (as defined in IRC Section 4980(B)) has changed. Status changes may include, without limitation, situations where the COBRA Qualified Beneficiary becomes eligible for coverage under another Plan without pre-existing conditions or becomes eligible for Medicare;
- G. Compensate Keenan in accordance with the fee schedule set forth in Exhibit A, attached to and made a part of this Agreement;
- H. Timely pay all premiums, service fees, and related charges as they appear on the Keenan billing statement by the date set forth on the billing invoice;
- I. Notify Keenan of a change in premium or benefits at least sixty (60) days before the effective date of the change;
- J. Notify Keenan of a change in a Qualified Beneficiary's eligibility;
- K. Notify Keenan of any changes in its insurance carriers or administrative Service providers;
- L. Consult its own attorney, as necessary, for legal opinions regarding Client's and/or a Qualified Beneficiary' rights under COBRA, ERISA and/or any other applicable statute or regulation;
- M. If applicable, send Individual Conversion Policy Notices to COBRA participants; and
- N. Respond to requests from healthcare providers inquiries regarding an individual's eligibility for COBRA coverage as required under IRS COBRA regulations.

EXHIBIT B
DOCTORS' MEDICAL CENTER SAN PABLO
SCHEDULE OF FEES

Effective: **August 1, 2010** through **December 31, 2012**

Administration Forms Fees (including ID Cards) (Exhibit A-1)

- Printing (per Original)
- Customization of Materials (per Form)

Cost + 10%

\$150.00

Claims Administration Fees (per EE and COBRA Beneficiary) (Exhibit A-1)

- Initial One Time Start-Up
- Medical/Vision
- Medical (census drops by 25%)
- Leave of Absence (per EE on direct billing per Month)
- Other Claim Administration Services
- Standard Run-In Claims (per Transaction)
- Run-Out Claims (Paid After Contract Termination Date)*
 *1st 4 months same as Admin. Fee paid in the month prior to termination and
 \$15.00 per processed claim thereafter
- Annual Renewal

\$5,000

\$21.50

N/A

N/A

N/A

\$12

\$21.50

Waived

UM/PPO Network Fees

- ANTHEM BLUE CROSS-UM/PPO
- HIP – Anthem Blue Cross Bariatric COE Fee (PEPM)
- Run-Out Claims (Paid After Contract Termination Date)*
 *First month following termination 50% of the monthly service fee;
 *Second month following termination 30% of the monthly service fee;
 *Third month following termination 10% of the monthly service fee;
 *Fourth through twelfth month following termination there is **no service fee.**
- Health Improvement
- Med Call Nurse Line

\$16.62

N/A

N/A

N/A

HIPAA Administration Fees (Exhibit A-3)

- Initial One Time Start-Up
- Certificates of Coverage (per Month)

N/A

Included with COBRA

Web Enrollment Access Fees (Exhibit A-4)

- Initial One Time Start-Up
- Monthly Access

N/A

N/A

Over-Age Dependent Notification Services Fees (Exhibit A-5)

- Initial One Time Start-Up
- Notifications (per Month)

N/A

Included

Third-Party Liability Recovery Services Fees (Exhibit A-6)

- Fees

30%

Vendor Disbursement Services Fees (Exhibit A-7)

- Fees

\$300

COBRA Administration Fees (Exhibit A- 8)

- Initial One Time Start-Up
- Notification and Premium Collection (per Active & COBRA EE per Month)
- Minimum Monthly

\$1.50

Included

\$250

MEDICARE Part D Fees (Exhibit A-9)

- Fees (PEPM)

N/A

Cost Containment Services

- Fees

*Services will be provided by one of various vendors with whom Keenan has contracted. Vendor fees will be a percent of Savings (35% maximum) and include an administrative fee paid by the vendor to Keenan.

*

Reprogramming Fees (\$200 minimum charge)

- Programmers (per Hour)
- Computer Time (per Hour)

\$150.00

\$100.00

Claims Management Reports (Ad Hoc) Fees

Subject to
Programmer and
Computer Time

Other

N/A

Late Charge Assessment (Applies to Fees 30 Days Past Due)

1.5% of past due fees

**West Contra Costa Healthcare District dba Doctors'
Medical Center San Pablo**

Keenan & Associates**Date:** _____**Initials:** _____**Date:** _____**Initials:** _____